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ABSTRACT

This report describes the University of Southern California's (USC) gerontology career preparation project, which was funded for the following training activities in mental health and aging: (1) traineeships for graduate students in USC's doctoral track in clinical psychology and aging and in the Leonard Davis School of Gerontology master's track in direct service; (2) partial core support for the Andrus Older Adult Center, the major practicum site for clinical training; (3) expanded contacts with the aging network; (4) development of clinical case materials, currently in draft form; and (5) evaluation of the training program. The narrative section of the report describes the purpose and significance of the project, support for trainers in the program, and the Andrus Older Adult Center. A list of program graduates along with their dissertation titles and present positions is provided. The project's aging network linkages, the development of casebook materials, and the evaluation design and results are described. The five appendices include a discussion of trainee achievements, the Andrus Older Adult Center brochure, the evaluation of the Los Angeles City Personal Emergency Response System, drafts of selected casebook material, and project evaluation measures. (MCF)

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Clinical Training in Aging and Mental Health

Final Report

Department of Health and Human Services

Office of Human Development Services

Grant No. 09-AT-33/01

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University of Southern California

31 May 1984

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ABSTRACT

This gerontology career preparation project, from October 1, 1982 to February 29, 1984, funded the following training activities in mental health and aging: (a) traineeships for graduate students in USC's doctoral track in clinical psychology and aging and in the Leonard Davis School of Gerontology master's track in direct service; (b) partial core support for the Andrus Older Adult Center, the major practicum site for clinical training; (c) expanded contacts with the aging network; (d) development of clinical case materials, currently in draft form; and (e) evaluation of the training program.

Each of the two academic tracks awards approximately three degrees per year, with students' progress toward graduation facilitated by training grant support. While trainees, students are active professionally, writing articles and book chapters, for example, and making presentations to local service providers and national professional audiences. Moreover, students provide service to clients at the Andrus Older Adult Center. The rough draft of the casebook, part of which is appended, gives an idea of the Andrus Older Adult Center clientele and treatment approaches used by trainees.

Among the activities with the aging network have been a conference on Brain Damage in the Adult Years, an evaluation of the Los Angeles AAA's Emergency Alert Response System (a program using Lifeline equipment connected to central response stations in local hospitals), and assistance in providing and evaluating an information and referral service at Andrus Gerontology Center. In all of these information-sharing and research activities, we have been impressed by the importance of family members--as caregivers for their physically frail or mentally impaired older relatives, and as people who themselves need emotional support, information, and assistance--and the importance of collaboration with the aging network in meeting those needs.

The evaluation of the training program found that trainees improved on the case description measure of knowledge in mental health and aging and on the Palmore Facts on Aging quiz; they also showed increased endorsement of public responsibility for the aged. Aging trainees shifted toward objectively less positive responses on a few attitude subscales, which we viewed as suggesting a healthy reduction in naive optimism as a consequence of their training experiences. When the gerontology and non-gerontology students were compared, those choosing a career serving the aged were found to have stronger relationships with their maternal grandmothers as children, but no support was found for the proposition that they had unusual fears of death or denial of the effects of aging. Rather, they liked working with older adults and genuinely wanted to be of service. Finally, the exposure experienced by the non-gerontological students by virtue of being in the same graduate department appeared to lead to increased knowledge about the aged and more positive attitudes toward them.

We are grateful for the support of OHDS in helping us to accomplish these activities.

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NARRATIVE

Introduction

The purpose of this project was to develop new directions in graduate training in mental health and aging at the University of Southern California. This career preparation program involves both doctoral students in clinical-aging psychology in the Department of Psychology and masters degree students in the direct service track of the Leonard Davis School of Gerontology at Andrus Gerontology Center. These two academic programs are coordinated by Drs. Margaret Gatz and Steven Zarit respectively.

The major facility in which both clinical-aging psychology doctoral students and Leonard Davis masters students receive practicum experience is the Andrus Older Adult Center (AOAC), a site where trainees and supervisors provide mental health services to older adults. The AOAC is directed by Steve Zarit, assisted by Nancy Orr. Further description of the AOAC is provided later in this report.

The project, which ran from October 1, 1982, to February 29, 1984, funded a number of specific activities related to the clinical training of the students:

1. Students were awarded traineeships, without which support they could not have completed their graduate education.

2. Core administrative functions and clinical supervision at AOAC received partial support. These activities are essential in order to provide a site for clinical training.

3. Contacts between the training program and the Aging Network were expanded, specifically, (a) by providing training in dementia and related topics for local agency personnel through the UCLA/USC Long Term Care Gerontology Center and the Los Angeles County AAA, (b) by conducting a program evaluation for the Los Angeles City AAA, and (c) by having trainees work in Information and Referral along with older adult volunteers at Andrus Gerontology Center.

4. A start was made on developing clinical case materials for use by our trainees and for eventual dissemination to other training programs.

5. An evaluation of the clinical training program at AOAC was undertaken. This report documents progress to date for each of these activities.

Significance

This career preparation program directly addresses the need for trained personnel in mental health and aging. The need has been frequently documented, for example, by Birren and Sloane's 1977 "white paper" on manpower and training needs in mental health and illness of the aging, and by the report of the AoA-funded Mini-Conference on the Mental Health of Older Americans held in 1980 in support of the White House Conference on Aging. In psychology, the 1980

Human Resources Survey of the American Psychological Association indicated that only 108 out of 26,943 doctoral-level practitioners spent 50% or more of their time working with older adults. This figure, even if it is an underestimate of total psychological service provision to the aged, contrasts strikingly to Birren and Sloane's estimate that 2000 clinical psychologists specializing in older adults will be needed by 1988. Due to the insufficient numbers of trained doctoral-level professionals, many have urged a multi-level personnel system.

The activities funded by this project have addressed the need for personnel in several interrelated ways. Responsive to the idea of a multi-level personnel system, both clinical-aging psychology doctoral students and gerontology masters degree students are trained together in the same clinical setting. Responsive to the concern for a greater proportion of doctoral-level practitioners to be competent to work with older adults, the clinical-aging track is embedded in a general clinical psychology training program, and all students in that program receive at least some exposure to aging.

The development of training programs in the past has been hampered by a scarceness of trained faculty and supervisors, suitable clinical facilities, and useful training materials. The training program at USC is in the almost unique position of having both the faculty and the clinical facility, as well as a stable record of producing masters and Ph.D. graduates in the area of aging. The funds provided by this project have helped to support the clinical training facility, and importantly, to make the experiences of trainees there transportable to other training programs through the development of case materials. Moreover, graduates from the USC training program already are becoming faculty and supervisors themselves elsewhere.

Most significantly, this project has funded the collection of evaluation data to document the actual production of trained personnel by these two USC academic programs, their commitment to training and service, and their acquisition of specific knowledge and skills for working with the mental health needs of the aged. To some extent, this entire document represents the product of this evaluation effort. Results obtained from administration of measures directed at assessing the knowledge and skills gained by trainees from being in the program are in the fifth section below.

Trainee Support

This grant--which encompassed three academic semesters (Fall 1982, Spring 1983, Fall 1983)--has provided direct support for four doctoral students in clinical-aging psychology and five masters level students from the Leonard Davis School of Gerontology. In addition, during those same semesters, the training offered at the Andrus Older Adult Center has contributed to the graduate programs of three other Leonard Davis students, twelve other clinical-aging psychology students, five students from USC's general clinical psychology doctoral program, and four doctoral students from the California School of Professional Psychology. Furthermore, all students in the USC general clinical psychology program received some exposure to issues of older adulthood through their interviewing practicum and didactic coursework in assessment and psychopathology.

Since October, 1982, three of the five Leonard Davis trainees have graduated and the other two expect to receive their M.S.G. degrees in January 1985. Two clinical-aging psychology students have finished their Ph.D.'s, with two more expected to finish in September, 1984. Three of the clinical-aging students completed their master's theses and are continuing on in the program toward a Ph.D. The thesis or dissertation titles and the post-graduate employment of all graduates are shown in Table 1.

All clinical psychology students must take a year's internship before being awarded their doctorates, in addition to the practicum work at AOAC. During the period of the grant, clinical-aging students have accepted internshipsat: Loma Linda Veterans Administration Medical Center, Loma Linda, CA; Los Angeles County/University of Southern California Medical Center, Los Angeles; Didi Hirsch Community Mental Health Center, Los Angeles; Brentwood Veterans Administration Medical Center, Los Angeles; and Central Peninsula Mental Health Center, Kenai, Alaska.

While in the program, students have been active in research and professional meetings. For example, trainees have co-authored twenty published articles or chapters and presented three dozen papers. The tables in Appendix A summarize: (a) publications by clinical-aging trainees during the time of the training grant, (b) professional presentations by trainees, (c) funded grant proposals written by trainees, and (d) selected other professional activities in which trainees have been engaged. Their record of involvement is impressive, and the training grant support has been important in facilitating the students' productivity.

Andrus Older Adult Center

The AOAC is directed by Dr. Zarit with the assistance of Nancy Orr, who does all of the day-to-day administration, considerable amounts of clinical supervision, and some direct service to clients and families. Zarit and Gatz, along with Orr, co-lead a weekly case conference and provide on-going clinical supervision. The grant has provided a portion of Orr's salary, which has been vital to maintaining the Andrus Older Adult Center as a clinical training site. It also contributed to the summer salaries of Zarit and Gatz, essential to the clinic's year-round operation. Appendix B contains a brochure about the Center.

The sheer amount of clinical service provision by trainees is noteworthy. Over a one year period, clinical-aging doctoral students accounted for seventy-five diagnostic work-ups, saw seventy individuals or families for treatment, and worked with five groups. Leonard Davis trainees averaged about ten counseling cases apiece along with conducting clinical intakes and five to six hours per week of telephone counseling and I & R. Four of the trainees have co-led groups as well. Clients typically present with some mixture of depression, delirium, dementia (e.g., Alzheimer's disease), marital tension, or issues of assertion. The groups include support groups for caregivers of family members with Alzheimer's disease, autobiography groups, assertion training workshops for older women, and a rap group for facilitating the continued effective functioning of "well" older adults.

Table 1

1983-4 USC Psychology Department Clinical-Aging Graduates

Trainee	Thesis or Dissertation	Present Position
Mary Boutselis (M.A., 1983)	Use of the Luria-Nebraska Memory Test in diagnosis of senile dementia	(continuing in Ph.D. program)
Max Fuentes (M.A., 1984)	Fear of crime in the elderly: Its relation to leaving one's abode, self-reported health and sense of personal control	(continuing in Ph.D. program)
Kathleen Mahurin (M.A., 1984)	Depression, health, and somatic complaints in older adults	(continuing in Ph.D. program)
Connie Dessonville (Ph.D.,1982)	The role of anticipatory bereavement in the adjustment to widowhood in older women	Post-doctoral Fellow, NPI, UCLA
Michael Gilewski (Ph.D., 1983)	Self-reported memory functioning in young-old and old-old age. Structural models of predictive factors	Staff psychologist, V.A. Outpatient Clinic, Los Angeles
Curtis Hileman (Ph.D. exp., 1984)	Development and validation of an MMPI-168 (Moderator) Index for predicting the degree of configural similarity between MMPI-168 and standard MMPI profiles	Post-doctoral Fellow, Langley Porter Inst., Univ. of California, San Francisco
Samuel Popkin (Ph.D. exp., 1984)	Self-monitoring of daily memory functioning in older adults: Further work on the relationship between metamemory and performance	Post-doctoral Fellow, Neuropsychiatric Institute, UCLA

1983-4 Leonard Davis School of Gerontology Direct Service Track Graduates

Karen Smith (M.S.G., 1983)	(by comprehensive exam)	Director of a residential treatment facility, South Carolina
Terri McWilliams (M.S.G., 1983)	Senile dementia: Differences in caregiver burden between Black and white families	
Pamela Lillard-Todd (M.S.G., 1983)	A longitudinal study of family burden in Alzheimer's disease and related disorders	

Table 1 (Cont'd)

1983-4 Leonard Davis School of Gerontology Direct Service Track Graduates (Cont'd)

Trainee	Thesis or Dissertation	Present Position
Shawn Herz (M.S.G., exp. 1984)	(by comprehensive exam)	Case Manager, Culver City Home Health Services
Shari Miura (M.S.G., exp. 1984)	Incontinence in senile dementia patients: Effects on caregiver burden	

Current employment of a sample of previous graduates

Debra Cherry (Ph.D.,1982)	Psychologist and Consultation & Education Specialist, City of Gardena Senior Day Center, Gardena CA
LaDonna Ringering (Ph.D.,1982)	Psychologist and Clinical Coordinator of Services, Center for the Partially Sighted, Santa Monica, CA
Kenneth Cole (Ph.D.,1981)	Psychologist, Geropsychology Program, East Foothill Guidance Clinic, Monrovia, CA
Anita Woods (Ph.D.,1980)	Research psychologist, Post doctoral training program in mental health and aging, Texas Research Institute for Mental Science, Houston, TX
Dolores Gallagher (Ph.D.,1979)	Director of Training, Geriatric Research, Education, and Clinical Center, Palo Alto VA Medical Center, Palo Alto, CA
Wendy Heinz (M.S.G.)	Instructor, Social Science Dept., Mount San Antonio College, CA
Chris Piatt (M.S.G.)	Gerontological Mental Health Specialist, Comprehensive Community Mental Health Center, Tacoma, Washington
Nancy Bopp (M.S.G.)	Private practice, North Hollywood, CA

The Leonard Davis students all share in the responsibilities of day-to-day operations like handling correspondence, light bookkeeping and financial management, and monitoring and updating the information and referral system. Consequently, they learn about operations and management of the AOAC services. All Leonard Davis students who received financial assistance from the training grant put in between 17-20 hours per week of work: 80% of this time was clinically related, 20% administrative. They averaged 3-6 hours more a week than a Leonard Davis student not receiving assistance.

Finally, trainees have been working as research assistants on several applied clinical research projects. The major study, on which Steve Zarit is principal investigator, is a controlled evaluation of individual and family therapy versus support groups as treatment for families of older adults with Alzheimer's disease. Six or more trainees have been assisting with this study. Another study, involving both Zarit and trainee Pam Lillard, is following up Alzheimer's patients after two years to find out whether they are still living at home with their families and what changes in the family's sense of burden and distress have taken place over that time. A third study--with Orr, Dr. Joseph Ouslander, and trainee Wendy Weicker--is investigating incontinence in patients with senile dementia and its effects on caregiving. A final study--with Bonnie Hedlund--is looking at the effects of the autobiography group in treating depression. These research projects serve to enrich the clinical experience of the trainees and enhance the service provision offered at AOAC, as well as add to the existing knowledge base regarding clinical intervention.

Aging Network Linkages

Lack of articulation between the mental health system and aging service agencies is often cited as a reason contributing to underserving or misserving older adults who are in need of mental health services. Consequently, attention was paid to insuring that trainees gained exposure to the aging network.

UCLA/USC Long Term Care Gerontology Center. During the grant period, AOAC personnel have provided presentations, workshops, and technical assistance to a number of local agencies. The primary topic is caregiving in relation to senile dementia, although other aging-related topics have also been addressed. Trainees assist with these activities. As a result, experiences from working with AOAC clients are shared with agency personnel, who learn from attending the presentations; and the students gain through learning how to give talks and from interacting with the Aging Network. Many of these activities have been under the aegis of the UCLA/USC Long Term Care Gerontology Center.

One of the most significant of these workshops was a conference called "Brain Damage in the Adult Years: A Challenge for the Professional", co-sponsored by AOAC and the Family Survival Project of San Francisco. Nancy Orr coordinated the conference; trainee Terri McWilliams was co-coordinator; trainees Shari Miura, Shawn Herz, and Pamela Lillard also assisted.

Trainee Sam Popkin gave talks on daily memory and aging to the Andrus Volunteers (October, 1983), the American Association of University Women (January, 1984). St. Vincent Medical Center's program called "For Health's Sake" (February, 1984), and Santa Monica Senior Health and Peer Counseling (May, 1984). Margaret Gatz and trainee Max Fuentes gave a talk on the psychology

of aging for an April 1984 workshop about the aging process held in Anaheim at the annual convention of the American Alliance for Physical Education, Health, Recreation, and Dance.

Los Angeles City AAA. Seven USC clinical-aging psychology students, one California School of Professional Psychology student, one Leonard Davis student, and a number of undergraduates, all under Margaret Gatz's supervision, have nearly completed a program evaluation project in cooperation with the city AAA. The AAA established a city-wide Emergency Alert Response System (EARS). EARS places emergency units in the homes of frail older persons who live alone, with emergencies being signalled to central response stations in local hospitals. The UCLA/USC Long Term Care Gerontology Center provided a small seed grant to begin the project. Students who have been involved in the project have gained experience in workingwith the staff at the hospitals and the AAA.

The evaluation is nearly complete. Pre-post data are all collected and analyses are proceeding. We were fortunate to have the opportunity to present preliminary results at a symposium in August 1983 on Aging and Technological Advances sponsored by the NATO Special Programme Panel on Human Factors. That presentation will be included in a book of the conference proceedings to be published by Plenum. A copy of the manuscript is attached as Appendix C. In addition, the EARS data set was used by students for one paper at the 1983 American Psychological Association Convention and one paper at the 1983 meetings of the Gerontological Society of America and will be used for two papers at the 1984 American Psychological Association Convention.

Information and Referral. All trainees spend some time working on information and referral, either at AOAC or at the Andrus Gerontology Center, under the supervision of Margaret Gatz, Nancy Orr, and the Information and Referral specialist. This person (at various times, Betty Powell, Natalie Bellick, Frances Hess), a portion of whose salary was paid by the grant, works at AOAC and has assisted at the Andrus Gerontology Center one day per week. The experience of maintaining a resource file, in order to make appropriate referrals, has been of particular importance in familiarizing students with the Aging Network services.

The group at the Andrus Gerontology Center, known as Resource Counselors, includes both trainees and older adult volunteers. Goldenera has provided funding to cover mileage for the Andrus Volunteers, telephone bills, supplies, and a portion of the time of a student during the summer.

The Resource Counselors are a volunteer information and referral program that was formed in response to unsolicited callers to Andrus Gerontology Center seeking information regarding community services for older adults. It was also intended to serve a training function. It is a referral service and not a counseling facility, nor does it usually directly contact agencies on the caller's behalf. The Resource Counselors staff an office in the Andrus Gerontology Center for approximately two to four hours each work day. The main reception desk at the gerontology center is equipped to transfer in-coming calls to the I & R office and to note

messages for the Resource Counselors should the office be closed. These latter calls are then returned during the regular operating hours.

All in-coming calls are reviewed at mandatory supervisory meetings. Suggestions for additional referrals or improving caller-counselor interactions are discussed and mail inquiries needing responses are assigned to specific Resource Counselors.

In the 1982-83 fiscal year, the Resource Counselors reponded to approximately 627 calls. Roughly 25% of those were handled by graduate student trainees, 4% by undergraduates, and the remaining by the older volunteers.

It is estimated that 25% of all in-coming calls concerned older individuals suffering memory loss or dementias. This high prevalence may be due to the age of the population served, coupled with the reputation of the Andrus Gerontology Center for its research in Alzheimer's disease.

Resources most frequently sought by callers were medical and psychological service referrals (25% each). Other common requests were for information regarding in-home care, nursing home placements, and clarification of problems. This last concern is largely a matter of consultation and less of agency referral, and the Resource Counselors' skills of listening, redefining problems, and empathic responses are especially important.

It is interesting to note that many callers are second or third parties. Only about a third of the in-coming calls are from people seeking resources for their own immediate self-use. Second generation relatives such as adult children and grandchildren constitute a fair percentage of callers (37%), which is surprising considering that only about 5% of the calls are from spouses. Professional service providers or academicians also use the service and comprise 10% of the calls.

Chris Anne Wolfe, one of the clinical-aging doctoral students supported on the training grant, has been conducting an evaluation of the Resource Counselors. Based on two sources of data -- (1) calling back a sample of 39 callers, and (2) checking AOAC records to see which callers followed through when they were referred there -- she estimates that roughly 59% of those calling are helped with referrals or consultation. An additional 10% of the callers report that merely having the names of agencies or resources was sufficient. She is presently writing up these data for Goldenera and for professional dissemination.

Casebook Materials

The idea of the casebook is to develop written materials for use by our own students as well as by trainees elsewhere. While in recent years there has been an increase in material and books on mental health and aging, they primarily contain only short vignettes. More extensive examples would better capture subtleties in assessment and diagnosis, and would provide a sense for how treatment procedures are implemented in actual complex cases. The casebook as envisioned would be useful for other audiences as well: students in gerontological disciplines not directly

concerned with mental health, aging network personnel, and mental health professionals who do not have specialized training in aging.

When we have told people about the project, we have found a great deal of interest in the casebook, both by professional colleagues at other training programs and by book publishers, suggesting that the casebook will be an effective vehicle of dissemination. Our piloting efforts to date have involved giving copies of the cases from the evaluation measures to colleagues at USC and elsewhere for use in teaching (these cases are described in more detail in the next section of the report). Their response confirms our enthusiasm for the project.

At present we have generated over 100 manuscript pages of material, including write-ups of nine cases and one therapy group. The draft is still quite rough, but has the advantage in its present form of conveying the types of notes that trainees keep as they are beginning to work with older clients. Subsequent drafts will apply a uniform outline for all cases, will focus more on the presenting problem--conceptualization, assessment, differential diagnosis, etiology--and will use each chapter as a platform from which to discuss one or two key topics in mental health and aging. The final prepublication draft will be piloted with aging network audiences and sent to AoA. Four selections, still in rough draft form, are included in Appendix D.

Evaluating the Training Program

The data on trainees presented earlier show that students are graduating from the program and taking positions where they serve the aged and provide training for other students and paraprofessionals. Furthermore, the data indicate that the trainees are highly productive while they are in the program, writing papers and giving talks to professional organizations and local aging network agency personnel. In sum, we have documented a successful gerontology career preparation program.

In this section we focus on looking specifically at the knowledge and attitudes of students while they are in the program, and how their knowledge about the mental health of older adults changed over the 17 months of the grant period. We saw this effort, although limited in its rigor by the small number of trainees and by the short length of time over which to observe changes, as a valuable first stop in assessing the effectiveness of the training model--in particular, the effect of training experiences at AOAC. Intriguingly, the measures that we developed for this evaluation have already been adopted for use elsewhere, suggesting that the evaluation design and instruments may be yet one more product for dissemination from this project.

Overview of design. Five groups of students were assessed: Leonard Davis School of Gerontology students in the direct service track who were trainees at the AOAC, a comparison group of Leonard Davis students who were trainees in tracks other than direct service, clinical-aging psychology doctoral students, clinical psychology students from USC whose specialization

was in an area other than aging, and doctoral students from the California School of Professional Psychology (CSPP) who were trainees at the AOAC. Because of the pervasiveness of gerontology at USC, we had also hoped to obtain data from non-gerontological doctoral students in clinical psychology from CSPP or another university other than USC in order to get a more accurate baseline for the level of knowledge and attitudes of typical clinical psychology students; however, this effort had to be postponed.

The evaluation was designed to tap students' knowledge about aging as well as their skills in assessment and intervention. Attitude measures were also included, primarily as a descriptive variable in comparing aging trainees with other students. The measures (see Appendix E) included:

1. Pruchno and Smyer's (in press) quiz of knowledge of mental health and aging;

2. Palmore's (1977) quiz of general knowledge of facts about aging;

3. a case description measure (Gatz, Pearson, and Zemansky, 1982) in which students were given two intake summaries and asked to write up a diagnostic assessment and treatment plan;

4. both Kogan's (1961) and the Ontario Welfare Council's (1974) scales of attitudes toward the elderly;

5. psychological measures hypothesized to covary with attitudes and with choosing a career in gerontology: functionalistic ethic (Sherman, 1981), intolerance of ambiguity (Budner, 1962), Machiavellianism (Christie, 1970), and anomie (McClosky & Schaar, 1963);

6. background information on trainees such as previous experience serving with older adults, interaction with their grandparents, reasons that they chose to go into a career in gerontology.

Additionally, the clinical skills of trainees were assessed by video-taping students interacting with older and younger volunteers who presented problems to the students similar to some of the interpersonal issues that might be raised by clients. It is planned to score the tapes according to students' use of helping skills (Hill, 1978) and to compare clinical-aging with clinical students in terms of their patterns of interaction with older and younger "volunteer clients". As of this date, the rating of the tapes has not yet been started.

There were four times of measurement. Table 2 shows the schedule of data collection.

Results on the case description mesure. This measure, developed for the present study by Gatz, Pearson, and Zemansky from composites of real AOAC intake summaries, can be found in Appendix E. At time 1, all students were given descriptions of two typical intake cases involving older adults and asked to write up a diagnostic assessment and treatment plan for each. Half received set A (Peggy S.; Sherman and Sally K.) while half received

TABLE 2

Schedule of Data Collection

	Jan 1983	May 1983	Sept 1983	Jan 1984
Leonard Davis School students: AOAC trainees	time 1* (N=4)	time 2 (N=4)	time 3 (N=4)	time 4 (N=4)
Leonard Davis School comparison students	time 1 (N=3)	time 2 (N=3)		
California School of Professional Psychology: AOAC trainees	time 1 (N=2)	time 2 (N=2)		
Clinical-aging psychology trainees	time 1 (N=11)	time 2 (N=11)	time 3 (N=11)	time 4 (N=11)
Clinical psychology comparison students	time 1 (N=19)	time 2 (N=12)	time 3 (N=12)	time 4 (N=12)
New clinical-aging psychology trainees			time 1 (N=4)	time 2 (N=4)
New clinical psychology comparison students			time 1 (N=10)	time 2 (N=10)

*Measures:

time 1: videotaped interviews
case description pretest
knowledge and attitude questionnaire
demographic and experience questionnaire
time 2: case description posttest
knowledge and attitude questionnaire
experience update
time 3: knowledge and attitude questionnaire
experience update
time 4: knowledge and attitude questionnaire
experience update

set 1 (Reggie W.; Ruth T.). At time 2, all students were again given two cases, with those who had done set A at time 1 now receiving set 1, and vice versa. The case descriptions were rated without knowledge of the students' identity or whether it was pretest or posttest.

For a first look at the data, each written description was simply assigned a "grade" from A to D (there were no Fs). Criteria that went into the grade included: correct assessment of whether the presenting problem was organic or nonorganic (or whether making this diagnosis required further assessment), identification of reversible conditions, discussion of the possible influence of physical health and drugs on psychological status, mention of the implications of the client's life history for diagnosis and treatment, consideration of family supports and social networks, and description of relevant psychotherapeutic techniques. Interrater reliability was by consensus.

Change scores were calculated by comparing the two grades given at time 1 to the two grades at time 2. We found that the Leonard Davis School trainees improved, while the Leonard Davis control students declined slightly. Clinical psychology students not specializing in aging showed substantial improvement, clinical-aging students on the average did not change over the two times of measurement, and the CSPP students who were trainees at AOAC improved slightly.

To understand these patterns, we looked at the score levels at both pretest and posttest. Leonard Davis students supported our hypothesis; both trainees and control students scored relatively low at time 1. At time 2, after a semester's training at AOAC, the trainees had made marked gains. For clinical-aging psychology students, the measure showed a ceiling effect. These students scored relatively high at both time 1 and time 2, and they had little room to show improvement. While statistically this result was disappointing, it does show the level of expertise these students had already attained. On the other hand, we were surprised and encouraged by the results for the clinical psychology students. While their time 1 scores were relatively low, they improved over the semester, suggesting that mere exposure in classes and practica to peers whose specialty was aging had an influence on their knowledge of the mental health of older adults.

In sum, these results provide some support for the idea that students do learn skills applicable to treating older clients while working at AOAC and for the approach of having both gerontological and non-gerontological trainees in the same graduate program.

Results on measures of knowledge and attitudes. In order to determine whether students changed over the time that they were in the training program, two main types of analyses were conducted. (a) First, repeated measures analyses of variance were carried out for the clinical-aging psychology students over four times of measurement, then separately for the clinical psychology comparison students over four times of measurement. Within this approach, follow-up paired t-tests were used to look at time 1 versus time 2 for each group of students, permitting a larger sample than was available for the full four times of measurement. (b) The second type of analysis involved paired t-tests in which one score (pre-test) was the student's level on the dependent variable just before being placed at AOAC, and the other score (post-test) was

the student's level on that variable after a semester's practicum at AOAC. Over the three semesters of the grant period, a total of 16 students (7 clinical-aging, 3 clinical psychology, 2 CSPP, and 4 Leonard Davis students) spent time training at AOAC and were available for these analyses. The mean scores corresponding to each analysis can be found in Table 3.

In effect, the numbers of subjects per cell, and the fact that we have a variety of comparison groups rather than any single formal control group, precluded more elaborate multivariate techniques. Nonetheless, the combined findings across analyses formed a consistent and interpretable pattern. That pattern has the gerontology students (clinical-aging and Leonard Davis) gaining in knowledge about aging, thinking less stereotypically about the aged, and endorsing a more self-reliant stance on the part of older adults. Clinical students, in comparison, showed some gains in knowledge and attitudes, although remaining less knowledgeable and less positive than the gerontology students. In other words, differences between groups of students were in the predicted direction, but again there appeared to be some effect on the clinical students of simply having indirect exposure to aging content and contact with peers specializing in gerontology.

In more detail, there were two measures of knowledge, Pruchno and Smyer's questions about mental health and aging and Palmore's Facts on Aging quiz. On the Pruchno and Smyer measure, gerontology students stayed constant at about 85% correct (although at time 3, the clinical-aging students got up to 90%), while the clinical psychology comparison students stayed constant at about 80% correct. There was significant change on the Facts on Aging quiz, involving gain on the part of both groups. From time 1 to time 2, clinical-aging students improved by an average of one additional correct item. This change was at the level of a statistical trend. The clinical students not specializing in aging started out getting an average of three more items wrong than did the clinical-aging or Leonard Davis students. They showed little improvement at time 2, but by time 4 they had increased significantly, although they were still below the initial level of the aging students. By time 4, clinical-aging students had an average of about 89% correct and Leonard Davis students 93%, while clinical students averaged about 76%.

On the attitude measures, all gerontology students showed several changes on the Ontario Welfare Council subscales, and both aging and non-aging students changed on the Kogan measure of attitudes toward the elderly. As would be expected, clinical-aging students were consistently more positive than clinical students on the Kogan measure. However, from time 1 to time 2, clinical-aging students became less positive (specifically, they agreed significantly more with negatively worded statements), while both Leonard Davis students and clinical students became significantly more positive. For both the clinical-aging and clinical groups, over times 3 and 4, attitudes leveled off closer to initial levels than to time 2 scores.

On the Ontario subscales, from time 1 to time 2, both the clinical-aging trainees alone and the entire group of gerontological trainees moved in the direction of more toughness and cynicism about older persons. However, for clinical-aging trainees, there tended to be a shift back to lower levels of cynicism at times 3 and 4. An example of the type of item scored on this subscale would be "old age is OK for those who are financially independent." Two other subscales where students showed changes were family responsibility and

Table 3

Mean Scores on Knowledge and Attitudes Questionnaire Scales

	clinical-aging psychology				all gerontology		clinical psych. comparison				placed at AOAC	
	time 1	time 2[a]	time 3	time 4[b]	time 1	time 2[a]	time 1	time 2[a]	time 3	time 4[b]	pre test	post test[c]
Pruchno & Smyer	12.8	13.0	13.7	12.9	12.6	12.6	11.9	11.9	11.5	12.5	12.6	12.8
Palmore: Facts on Aging quiz	20.9	21.7^{t}	22.3	22.0^{t}	21.0	21.6	17.2	17.8	18.2	19.0*	20.8	21.6**
positive bias	10.9	3.6	3.6	1.8	14.2	5.8*	31.7	25.0	20.0	16.7	15.0	8.8
negative bias	14.2	13.6	10.2	13.1	13.8	14.1	26.0	26.0	25.0	24.0	15.6	12.9^{t}
Kogan: total	196.5	192.0	200.6	200.0*	194.5	194.0	183.3	186.9*	183.2	183.1	193.1	194.3
positive	91.3	91.1	94.4	95.2	89.7	89.9	84.0	87.2**	87.0	85.8	88.4	89.1
negative	105.3	100.9*	106.3	104.8*	104.8	104.2	99.3	99.7	96.2	97.3	104.7	105.2
Ontario Welfare Council: toughness	55.0	60.5**	52.7	54.3^{t}	51.0	57.7**	53.4	57.3	58.9	57.7	51.4	54.8
denial	6.9	7.8	6.8	7.9	6.8	7.8^{t}	8.5	8.8	9.1	9.3	7.0	7.9
anxiety	43.2	45.5	41.3	45.4	43.6	41.5	46.1	53.2	50.0	52.8	46.4	45.6
social distance	45.3	48.5	44.0	44.8	42.1	43.0	44.7	48.4	51.6	49.3	44.0	43.1
family responsibility	86.3	96.4^{t}	93.9	95.9	86.8	96.0*	91.3	95.2	83.6	96.4*	82.2	92.4^{t}
public responsibility	88.1	94.9^{t}	93.4	93.1^{t}	88.9	93.8**	88.4	80.8	86.7	81.3	86.2	91.9*
stereotyping	20.5	23.4**	20.2	21.7^{t}	20.0	22.8**	23.8	24.2	26.2	25.9	21.2	22.6

[a] results of paired t-tests comparing time 1 to time 2 (N= 15 for clinical-aging, 24 for all gerontology, 29 for clinical psych. comparison)

[b] results of repeated measures analyses comparing the four times of measurement (N= 10 for clinical-aging and 12 for clinical)

[c] results of paired t-tests comparing trainees before and after placement at AOAC (N=16)

t $p < .10$

* $p < .05$

** $p < .01$

public responsibility. Gerontology students in particular indicated increased belief in both family and public responsibility, and the clinical psychology comparison students changed toward endorsing more family responsibility. Typical items scored on these subscales would be: "relatives...rightly expect the children to care about their well being if they live a very long life"; "old age pensioners have a right to be taken care of in a dignified way even if younger people must contribute their taxes to make this possible." Finally, on the subscale of stereotyping the aged, gerontology students--especially clinical-aging students--moved significantly toward adopting more unfavorable stereotypic images of the aged (e.g., "no one who is retired and over 70 should be allowed to drive a car"), although still less stereotypic than the clinical psychology comparison students.

Interpreting attitudinal measures is complicated; scoring in an apparently more "ageist" direction could indicate negative attitudes, or lack of knowledge, or a realistic image of some of the problems, difficulties, and limitations that older individuals really do have. We have opted for the latter interpretation of changes on the Kogan and Ontario measures; in both instances, there was a shift toward more endorsement of negative statements, but with the mean score still quite positive. Our interpretation is further supported by results on the bias scores calculated from the Facts on Aging quiz. Two error scores were calculated: the percent of errors that involve making overly positive attributions, and the percent of errors that involve making overly negative attributions. The results showed that, taking all gerontology students together, there was a significant drop in positive bias, but no change in negative bias. Taken in the context of improved scores on the quiz, this result is consistent with the interpretation that students are not so much becoming more "ageist" as they are moderating overly positive attitudes and becoming tougher and more realistic. Moreover, becoming more realistic and recognizing the problems of older individuals apparently goes along with greater commitment of family and especially public resources to helping those who need it.

Finally, for just the students placed at AOAC whose pretest and posttest scores were compared, there was a significant increase on Palmore's Facts on Aging quiz scores, a trend toward decreased positive bias, and endorsement of more public responsibility for the aged. This combination of results, while still suggestive rather than definitive, does document a coherent effect due to students' training experience.

Reasons for choosing a career in gerontology. In their key volume on aging and mental health, Butler and Lewis (1982) presume that a pervasive societal ageism is largely responsible for a dearth of service profiders trained and working in aging. They observe that most people say that they got into aging by chance, and they suggest that practitioners will avoid taking the unpopular stance of asserting that they are genuinely attracted to old people and aging. Butler and Lewis go on to offer eight motivational hypotheses that they think might account for a person's interest in aging:

"1. Particularly warm relationships in childhood with grandparents...
2. Early dependence on grandparents...or on older persons...
3. Death or painful illness of an important older person when a child is young and extremely impressionable...

4. Unconscious counterphobic attempt to conquer one's own personal fear of aging and death
5. Conscious attempt to 'prepare' for one's own old age, especially if the models of parents or grandparents are unacceptable...
6. Personal sense of inferiority that causes one to identify with older people, who are culturally defined as inferior
7. Guilt and subsequent reaction formation for feelings of fear and revulsion toward the aged
8. Admiration for and identification with someone working in the field of aging" (p. 183)

Data collected during the pretest phase of the evaluation allowed for a comparison of clinical psychology students who have elected an aging specialty with students who share the same academic milieu but have other specialties. Preliminary analyses lend partial support to the first three hypotheses, but not in a straightforward way. Clinical-aging students reported a higher frequency of visitation with their maternal grandmothers in childhood (46.7% saw them daily or several times a week) than their clinical counterparts (34.5%). Only 80% of the clinical-aging students reported daily contact with their fathers, compared to 93.1% for the clinical. When asked to indicate the valence of these significant childhood relationships, clinical-aging students rated maternal and maternal-grandmother relationships higher than did the clinical students (4.5 vs 4.1 for mothers, 3.7 vs 3.1 for grandmothers, on a 5-point scale). The frequency of grandfather's death during childhood was higher for clinical-aging students, and of grandmother's death for clinical. Yet, when asked to rate individuals according to their influence on them, only 27% of clinical-aging students ranked maternal grandmothers among the top three, in comparison to 38% of the clinical students. What is beginning to emerge is a pattern wherein the clinical-aging group is characterized by stronger and more positive relationships with mothers and maternal grandmothers in childhood, coupled with less strong ties to fathers and grandfathers. It is possible that the lower influence ratings indicate that clinical-aging students may be more inclined to see themselves as contributing to, rather than depending on, their grandmothers, as Butler and Lewis suggest.

Four of the remaining five of Butler and Lewis' hypotheses involve negative reactions or fear about old people, aging, and death. All groups of trainees fell close to neutral on fear of death; all endorsed low levels of denial of the effects of aging, with the gerontology groups scoring lowest; and clinical-aging students were considerably less anxious about aging than their clinical counterparts. With respect to negative attitudes towards the aged as measured on the Kogan scale, all students scored on the positive end of the scale, and aging students were the most positive. Aging students endorsed fewer unfavorable stereotypes on the Ontario Welfare Council subscale and scored lower on items tapping social distance from older people. These results give little support for ageism among these groups of trainees, or for strong reactions to ageist attitudes on the part of those specializing in aging.

When trainees were asked to rate 15 reasons according to how influential they were in their choice of specialty (1=not at all, 5=very much), clinical-aging students rated "interacted well with the population served" highest, while Butler and Lewis' eighth hypothesis--"had an important role model" and "had a particularly inspiring mentor"--fell below the midpoint. Their second highest

ratings went to "wanted to be of service, to be helpful" and "wanted to facilitate social change". Circumstantial opportunities (chance factors) such as receiving a training stipend or a research position ranked at the bottom. Clinical students not specializing in aging ranked important role models near the top, above interacting well with the population. Although other aging students rated role models somewhat higher than the clinical aging students, for them as well, getting along well with old people was by far the most important influence.

In summary, these students preparing to work with older adults and aging seem quite willing to say they are doing so because they like old people. Patterns of relationships with older relatives, especially maternal grandmothers, may be important to their receptiveness to older adults, which is reflected in more positive attitudes, decreased social distance, and less fear and denial of the effects of aging. These explorations, when complete, should be useful in recruiting gerontology trainees to meet the future mental health needs of older adults.

Summary of Future Work and Materials to be Sent to OHDS

As is apparent, this report is final in name only. We have been describing an ongoing training program and an evaluation that is still in progress. Zarit and Gatz will continue editing and piloting the clinical casebook; the final draft will be sent to OHDS. Gatz and Pearson will continue looking at the evaluation data, including the videotaped interviews which have not yet been coded; copies of results of future analyses will be provided to OHDS.

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Gatz, M., Pearson, C., & Zemansky, M. A case description measure for assessing knowledge in mental health and aging. OHDS Grant No. 09-AT-33/01, 1982.

Hill, C.E. Development of a counselor verbal response category system. Journal of Counseling Psychology, 1978, 25, 461-468.

Kogan, N. Attitudes toward old people: The development of a scale and an examination of correlates. Journal of Abnormal and Social Psychology, 1961, 62, 44-54.

McClosky, H. & Schaar, J.H. Psychological dimensions of anomy. American Sociological Review, 1963, 30, 14-40.

Ontario Welfare Council, Opinions about people--Form A--Guidelines and manual. Ontario Welfare Council, Toronto, Section on Aging. 1974.

Palmore, E. Facts on aging: A short quiz. Gerontologist, 1977, 17, 315-320.

Pruchno, R. & Smyer, M.A. Mental health problems and aging: A short quiz. International Journal of Aging and Human Development (in press).

Sherman, E. Counseling the aging: An integrative approach. New York: The Free Press, 1981.

Appendix A

Trainee Achievements During the Grant Period

Table A1

Clinical-Aging Trainee Publications 1982-84

Carter, J. E., Obler, L., Woodward, S., & Albert, M. A. (1983). The effect of increasing age on the latency for saccadic eye movements. Journal of Gerontology, 38.

Gatz, M., Eiler, J., Pearson, C., Gilewski, M., Fuentes, M., Zemansky, M., Emery, C., & Dougherty, L. (in press). Evaluation of a personal emergency response system. In P. Robinson, J. Livingston, & J. E. Birren (Eds.), Aging and Technological Advances. New York: Plenum Publishing Co.

Gatz, M., Hileman, C. S., Amaral, P. (in press). Older adult paraprofessionals: Working with and in behalf of older adults. Journal of Community Psychology.

Gatz, M., Pearson, C., & Fuentes, M. (1984). Older women and mental health. In A. Rickel, M. Gerrard, & I. Iscoe (Eds.), Social and psychological problems of women: Prevention and crisis intervention. Washington, D.C.: Hemisphere.

Gatz, M., Popkin, S. J., Pino, C. D., & VandenBos, G. R. (in press). Psychological interventions with older adults. In J. E. Birren & K. W. Schaie (Eds.), Handbook of the psychology of aging (2nd ed.). New York: Van Nostrand Reinhold.

Gilewski, M. J., & Zelinski, E. M. (in press). Assessment of memory complaints in community-dwelling elderly. In L. W. Poon, et al. (Eds.), The handbook of clinical memory assessment of older adults. Washington, D.C.: American Psychological Association.

Hedlund, B., & Ebersole, P. (in press). Male mid-life transition and changes in meaning in life. Journal of Genetic Psychology.

Hedlund, B., & Lindquist, C. (in press). An inventory to distinguish among passive, assertive, and aggressive behaviors. Behavioral Assessment.

Izard, C. E., Hembree, E. A., Dougherty, L. M., & Spizzirri, C. C. (1983). Changes in facial expressions of 2-to 19-month-old infants following acute pain. Developmental Psychology, 19, 418-426.

LaRue, A., Dessonville, C. L., & Jarvik, L. (in press). Aging and mental disorders. J. Birren & K. W. Schaie (Eds.), Handbook of the psychology of aging (2nd ed.). New York: Van Nostrand Reinhold.

Marston, A., Hart, J., Hileman, C. S., & Faunce, W. (in press). Toward the laboratory study of sadness and crying. American Journal of Psychology.

Table A1 (Cont'd)

Clinical-Aging Trainee Publications 1982-84 (Cont'd)

Obler, L., Woodward, S., & Albert, M. L. (1984). Cerebral lateralization in aging. Neuropsychologia, 22, 235-240.

Pearson, C., & Gatz, M. (1982). Health and mental health in older adults: first steps in the study of a pedestrian complaint. Rehabilitation Psychology, 27, 37-50.

Popkin, S. J., Gallagher, D. E., Thompson, L. W., & Moore, M. E. (1982). Memory complaint and performance in normal and depressed older adults. Experimental Aging Research, 8, 141-145.

Popkin, S. J., Schaie, K. W., & Krauss, I. K. (1983). Age-fair assessment of psychometric intelligence. Educational Gerontology, 1, 47-55.

Schienle, D. R., & Eiler, J. (in press). Clinical intervention with older adults. In M. G. Eisenberg, M. Jansen, & L. Sutkin (Eds.). The impact of chronic disability conditions on self and family: A life span approach. New York: Springer.

Tecce, J. J., Cattanach, L., Wrchick, D. A., Meinbresse, D., & Dessonville, C.L. (1982). CNV rebound and aging. Electroencephalography and Clinical Neurophysiology.

Tecce, J. J., Savignano-Bowman, J., & Dessonville, C. L. (1982). CNV and myogenic foundations: I. Muscle tension produces a dissociation of CNV and EMG. In J. Cohen, R. Karrer, & P. Tueting (Eds.), Proceedings of the Sixth International Conference on event related slow potentials of the brain. New York: Academy of Sciences.

Zarit, S. J., Eiler, J., & Hassinger, M. (in press). Clinical assessment. In J. E. Birren & K. W. Schaie (Eds.), Handbook of the psychology of aging (2nd ed.). New York: Van Nostrand Reinhold.

Zelinski, E. M., Light, L. L., & Gilewski, M. J. (in press). Age differences in memory for prose: The question of sensitivity for passage structure. Developmental Psychology.

Table A2

Clinical-Aging Trainee Professional Presentations 1982-84

Birren, J. E., & Hedlund, B. (1982, Fall). Aging and mental health. Oslo, Norway.

Birren, J. E., & Hedlund, B. (1983, August). Autobiography: A methodology for understanding issues in human development. Munich, Germany.

Birren, J. E., & Hedlund, B. (1982, June). The metaphors of aging and the self-constructing individual. Paper presented at a conference in Vancouver, British Columbia.

Boutselis, M. (1982, April). Use of Luria-Nebraska Memory Subtests in assessment of senile dementia. Paper presented at the meeting of the Western Psychological Association, Sacramento, CA.

Dessonville, C. L., Thompson L., & Gallagher, D. (1983, November). The role of anticipatory grief in the adjustment to bereavement in the elderly. Paper presented at the meeting of the Gerontological Society of America, San Francisco.

Dougherty, L. M., & Gatz, M. (August 1984). Changes in health, social contact and morale. Paper to be presented at the American Psychological Association annual convention, Toronto.

Fuentes, M. (1983, July 28). Differential diagnosis: Affective disorders and alcoholism. Veterans Administration Hospital, San Diego.

Fuentes, M., & Gatz, M. (1983, November 22). Fear of crime in the elderly. Paper presented at the meeting of the Gerontological Society of America, San Francisco.

Fuentes, M., Pearson, C., Sulliger, S., & Gatz, M. (August 1984). Fear of crime in the elderly: A longitudinal study. Paper to be presented at the American Psychological Association annual convention, Toronto.

Gatz, M., Eiler, J., Pearson, C., Gilewski, M., Fuentes, M., Zemansky, M., Emery, C., & Dougherty, L. (1983, August 23). Evaluation of a personal emergency alert response system. NATO Special Programme Panel on Human Factors: Aging and Technological Advances, Los Angeles.

Gilewski, M. (1983, September). Neuropsychology in an inpatient population. In-service training session for the Inpatient Psychiatry Service. Veterans Administration Medical Center, Loma Linda, CA.

Gilewski, M. J. (1984, May). Paradoxical interventions and systems therapy. Inservice training session held for Psychology Service. Veterans Administration Outpatient Clinic, Los Angeles, CA.

Table A2 (Cont'd)

Clinical-Aging Trainee Professional Presentations 1982-84 (Cont'd)

Gilewski, M. J., & Zelinski, E. M. (1983, October). Assessment of memory complaints in community-dwelling elderly. Invited paper presented at the Second George A. Talland Memorial Conference, Boston.

Gilewski, M. J., & Zelinski, E. M. (1982, August). Memory complaint and mood in the elderly: A new wrinkle. In T. M. Shlechter, D. J. Herrmann, & M.P. Toglia (Chairs), A symposium on current trends in everyday memory research. Symposium conducted at the meeting of the American Psychological Association, Washington, D.C.

Gilewski, M. J., & Schaie, K. W. (1983, November). Short-term longitudinal changes in memory, intelligence and perceived competence in older adults. Paper presented at the meeting of the Gerontological Society of America, San Francisco.

Gilewski, M. J., Zelinski, E. M., Schaie, K. W., & Thompson, L. W. (1983, August). Abbreviating the Metamemory Questionnaire: Factor structure and norms for adults. Paper presented at the meeting of the American Psychological Association, Anaheim, CA.

Gilewski, M. J., Zelinski, E. M., Thompson, L. W., & Schaie, K. W. (1983, April). Age and knowledge of historical factors. Paper presented at the meeting of the Western Psychological Association, San Francisco.

Hassinger, M. J., Zarit, J. M., & Zarit, S. H. (1982, April). Clinical characteristics of Alzheimer's and multi-infarct dementia patients. Paper presented at the meeting of the Western Psychological Association, Sacramento, CA.

Hileman, C. (1982, Summer). Diagnosis of sleep disorders with the elderly. Workshop presented at the Veterans Administration Hospital, Honolulu.

Hileman, C. (1982, Spring). Late life paranoid states. Workshop presented at the Veterans Administration Hospital, Honolulu.

Hileman, C., Amaral, P., & Gatz, M. (1982, August). Models and programs in peer counseling among older adults. Paper presented at the annual meeting of the American Psychological Association, Washington, D.C.

Krauss, I. K., Gilewski, M., Poon, L. W., & Schaie, K. W. (1982, November). Effects of biased sampling on cognitive performance. In L. W. Poon (Chair), On subject selection in cognitive aging research--Practice, impact and recommendations. Discussion session conducted at the meeting of the Gerontological Society of America, Boston.

LaRue, A., Dessonville, C. L., & Spar, J. (1983, August). Variation in cognition among elderly depressives. Paper presented at American Psychological Association, Anaheim, CA.

Table A2 (Cont'd)

Clinical-Aging Trainee Professional Presentations 1982-84 (Cont'd)

Mahurin, K. A., & Gatz, M. (1983, August). Depression, health, and somatic complaints in older adults. Paper presented at the annual meeting of the American Psychological Association, Anaheim, CA.

Mahurin, K., & Gatz, M. (1983, November). Complaint complexity: New approach to an "old" problem. Paper presented at the meeting of the Gerontological Society of America, San Francisco.

Obler, L., Woodward, S., & Albert, M. L. (1983, February). Cerebral lateralization in aging. Paper presented at the meeting of the International Neuropsychological Society, Mexico City.

Obler, L., Woodward, S., & Albert, M. L. (1983, February). Strategies for speech comprehension across the life-span. Paper presented at the meeting of the International Neuropsychological Society, Mexico City.

Pearson, C. (1983, February). Training psychologists for work in aging: The Older Boulder Conference. Symposium conducted at the annual meeting of the Association for Gerontology in Higher Education, Los Angeles.

Pearson, C., & Emery, C. (1983, August). Psychosocial consequences for older individuals of foot complaints and impaired mobility. Paper presented at the annual meeting of the American Psychological Association, Anaheim, CA.

Pearson, C., & Gatz, M. (1982, November 7). Older women and mental health: Issues in psychotherapy. Paper presented to the Association for Women in Psychology, Los Angeles.

Pearson, C., & Fuentes, M. (1983, April). Older women and mental health. Invited presentation, Symposium on International Issues of Women. Program for the Study of Women and Men in Society. University of Southern California, Los Angeles.

Popkin, S. (1984, May). Mechanisms of change in psychotherapy. West Los Angeles Veterans Administration Medical Center, Los Angeles, CA.

Popkin, S. (1984, May). Update on Kernberg's views on object relations theory and practice. West Los Angeles Veterans Administration Medical Center, Los Angeles, CA.

Pynoos, J., Stacey, C., & Rausch, K. (1984, March). Moving behavior, social interaction, and friendship maintenance in a continuum of care retirement community. Paper presented at the annual meeting of the Western Gerontological Society, Anaheim, CA.

Table A2 (Cont'd)

Clinical-Aging Trainee Professional Presentations 1982-84 (Cont'd)

Weicker, W., Stacey, C., & Gatz, M. (1984, April). Home sweet home: The woman's responsibility? Multigenerational families. Paper presented at the Western Psychological Association annual meeting, Los Angeles.

Zelinski, E. M., Light, L. L., & Gilewski, M. J. (1983, April). Adult age differences in memory for prose. In L. L. Light & D. Burke (Chairs), Semantic memory and aging. Symposium conducted at the meeting of the Western Psychological Association, San Francisco.

Table A3

Clinical-Aging Trainee Grant Proposals Funded 1982-84

J. Eiler, & S. Feldan. Fatigue effects in saccadic eye movements. Estelle Doheny Eye Research Foundation.

M. Gatz, & S. J. Popkin. Self-monitoring of daily memory functioning in older adults. USC Biomedical Research Support Grant.

B. Hedlund. Clinical application of guided autobiography as an intervention with depressed elderly. USC Faculty Research and Innovation Fund.

M. Gatz, & C. F. Emery. The effect of physical exercise on cognitive and psychological functioning in community aged. AARP/Andrus Foundation.

M. Gatz, & C. Pearson. A national survey of the provision of psychological services to older adults. Lexington Research Fund.

Table A4

Selected Other Professional Activities of Trainees 1982-84

B. Hedlund, M. Boutselis, & C. Pearson.
Students members of editorial board, American Journal of Community Psychology.

C. A. Wolfe, M. Boutselis, & C. Pearson.
Newsletter coordinators, Association for Women in Psychology, Los Angeles.

C. Pearson, M. Fuentes, L. Dougherty, C. A. Wolfe, S. Popkin, & K. Mahurin.
Assistant editors of Division 20 (Aging), American Psychological Association, Newsletter.

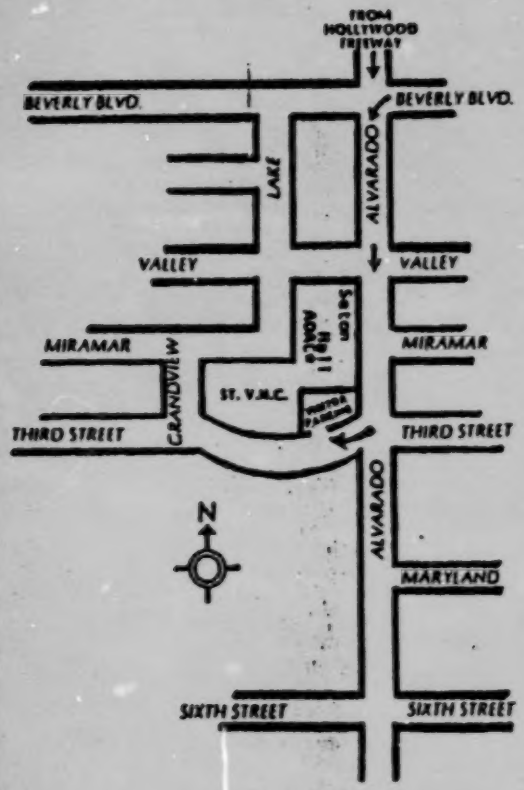
C. A. Wolfe.
USC student representative of Division 27 (Community), American Psychological Association.

B. Hedlund.
Pre-doctoral trainee, Andrew Norman Institute for Advanced Study in Geriatrics and Gerontology, 1983-84.

K. Mahurin, & W. Weicker.
Program assistants, Division 20 (Aging), American Psychological Association annual convention, Toronto, August 1984.

Appendix B

Andrus Older Adult Center Brochure



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Andrus Older Adult Center
Seton Hall Third Floor
262 South Lake Street
Los Angeles, CA 90057

(213)483-8802

Andrus Older Adult Center
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Los Angeles, CA 90057

ANDRUS

OLDER ADULT CENTER

29

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Sponsored by

Ethel Percy Andrus Gerontology Center,
University of Southern California

and

St. Vincent Medical Center

PURPOSE

The Andrus Older Adult Center offers a wide variety of services to the older adult. Our program is designed to assist with problems that may accompany the aging process. Whether you need information, face a personal crisis, or just want someone to talk with, we can help.

Throughout the three year history of the Andrus Older Adult Center we have provided an innovative and comprehensive approach to direct services for older adults and their families. The Center also serves as a training site for graduate students at the masters, doctoral, and post-doctoral levels. In addition, the Center conducts research in clinical work and service delivery with older people.

STAFF

The counseling staff includes licensed clinical psychologists, as well as gerontologists, peer counselors, and graduate students from various disciplines.

SPONSORSHIP

The Andrus Older Adult Center is a component of the Institute of Policy and Program Development of the Ethel Percy Andrus Gerontology Center and is affiliated with the St. Vincent Medical Center. Partial funding for the program is supplied by the Leonard Davis School of the Andrus Gerontology Center. The Center offers a wide range of services that are generally not available elsewhere. These include:

- Assessment and treatment of individual and family problems related to aging: DEPRESSION... MEMORY...RELATIONSHIPS... MARRIAGE...ASSERTION TRAINING... SEXUALITY...COMMUNICATION SKILLS.
- Counseling of families and caregivers of persons with Alzheimer's disease and related organic brain diseases: SUPPORT GROUPS...COPING SKILLS...PROBLEM SOLVING...STRESS MANAGEMENT.
- Weekly rap groups with opportunities for discussion and socialization.
- Occasional workshops, classes, and seminars.
- Information and referral to other community resources.

FEES

There are no set fees for our service. Donations, however, are requested and can be discussed in private with your counselor.

APPOINTMENTS

Please call 483-8802 for an interview appointment. Our office hours are 10 A.M. to 3 P.M. Monday through Friday. After-hours and Saturday appointments may be arranged under special circumstances. When necessary, home visits may be arranged.

HOW TO GET HERE

We are located in Seton Hall, on the grounds of St. Vincent Medical Center. Free parking is available. The Center can also be easily reached by bus. Our address is:

ANDRUS OLDER ADULT CENTER
SETON HALL, THIRD FLOOR
262 S. LAKE STREET
LOS ANGELES, Ca. 90057

Call RTD for bus info: 626-4455

Appendix C

Evaluation of the Los Angeles City AAA
Emergency Alert Response System

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EVALUATION OF A PERSONAL EMERGENCY RESPONSE SYSTEM*

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INTRODUCTION

Among the services thought to be essential to maintaining frail and vulnerable older adults in their own homes is emergency assistance when needed. A variety of electronic technological systems are now available to provide such a service. This paper reports some initial results from an evaluation of one program, Emergency Alert Response System (or EARS). The EARS program uses equipment from Lifeline Systems, Inc.

Lifeline is a technological system for connecting a frail older person's telephone to a central emergency operator at a hospital. The subscriber may summon emergency help actively by pressing a button on the Lifeline unit or on a portable trigger, or passively via a monitoring device which notifies the central operator if a preset timer is allowed to run out. Upon receiving a signal, the emergency operator contacts predetermined responders (a neighbor with a key or a nearby relative) and/or paramedics, police, or other services as needed. The service afforded by such a system is, in fact, twofold: first, the actual use of the unit in case of an emergency; and second, peace of mind from having the system constantly available.

Sherwood and Morris (1981) previously conducted a demonstration project with Lifeline. Subscribers, who lived in public housing, were identified to meet the criteria of three screening groups: (1) those who were severely functionally impaired and socially isolated, (2) those who were severely

functionally impaired but not socially isolated, and (3) those who were not severely functionally impaired but medically vulnerable and social isolated. Sherwood and Morris found that, for the group of users who were severely functionally disabled but not socially isolated (group 2), Lifeline resulted in more comfort and confidence in the ability to live independently and less use of nursing home care than matched controls who did not have the unit. For groups who were socially isolated and either severely functionally impaired or medically vulnerable, there were slight increases in anxiety. Sherwood and Morris subsequently developed a screening instrument for classifying subscribers into the three screening groups.

Writing about the same demonstration project, Dibner, Lowy, and Morris (1982) reported an average of .44 emergencies per Lifeline subscriber per year. Physical illness or accidents accounted for 73%, while environmental emergencies (assaults, maintenance problems) accounted for 27% of the calls. While emergencies typically were signalled by pressing the button, 22% of the time the emergency operator was reached by means of a telephone call placed by the subscriber or by a friend or relative.

There have been other studies, primarily in sheltered housing in the U.S. and Great Britain, which maintained records of the use of emergency alarm systems (e.g., Brenner, 1981; Butler, 1981; Garrow, 1976). The nature of the emergencies in all of the studies tended to be similar. The most common physical problem was falling; psychologically-related incidents tended to involve disorientation; environmental problems involved such things as vandals, kitchen fires, or inadvertently locking oneself out of the house.

Dibner (1982) surveyed the program coordinators at 72 of the more than 700 hospitals and agencies in the U.S. that have purchased Lifeline. These data are the first to describe naturally developing programs. There was an average of .84 emergencies per person per year, with quite a number of subscribers experiencing multiple emergencies. Of the incidents, 90% were physical health-related (again, falls were most frequent, followed by heart attacks) and 10% were environmental. Program coordinators felt that the system served to delay institutional placement for one-sixth of the subscribers.

In our study we were particularly interested in a number of issues related to the effect of this technological program on the elderly subscribers and their families: First, we wanted to look at the informal support system of the EAR subscriber. For instance, what is the role of the family in the decision to install emergency response equipment, and what is the effect of

the program on the relationship between the family and the subscriber? In particular, does the family feel less burdened? Furthermore, how does the neighbor who is participating as a responder feel about EARS? Second, we wanted to follow up on the differences attributable to EARS being a naturally developing program rather than a demonstration project. For example, in the current study, individuals who did not fall into one of the screening groups identified by Sherwood and Morris were not necessarily excluded from having a unit. Some units were purchased with Housing and Community Development Block Grant funds to be given to low-income elderly; in addition, the four hospitals which are operating central response stations leased other units to people who requested them.

METHODS

The four hospitals selected by the Area Agency on Aging to participate in the EARS program each agreed to provide the research team with the names of all subscribers whom the hospitals had approved to receive a unit. Subscribers were telephoned to request their participation in an evaluation study. Those who agreed were interviewed either before their unit was installed or within a short time of installation. They were also asked whether we might contact a member of their family and a neighbor who was serving as an emergency responder. If they agreed, we phoned these other people to request interviews. Post-test data were collected one year after pretesting. In addition, subscribers were phoned by a member of the research team every three months to ask about emergencies and other use of health-related services. Finally, with the subscriber's permission, we obtained copies from the hospital of all emergency incident reports.

The battery of measures for subscribers was designed to assess the constructs of interest to us. For comparison purposes, several measures similar to those used by Sherwood and Morris were included. The subscriber battery encompassed: (a) client descriptive variables: demographic information, the Lifeline screening instrument (Sherwood and Morris, 1981), mental status (Kahn, Pollack & Goldfarb, 1961), self-rated health (USHEW, 1978), physical illnesses (Pfeiffer, 1975), and activities of daily living (Pfeiffer, 1975); (b) mental health outcome variables: happiness as assessed by the Affect-Balance Scale (Bradburn, 1969), sense of mastery (Pearlin & Schooler, 1978), and psychiatric symptoms as assessed by the Brief Symptom Inventory (Derogatis, 1977); (c) outcome variables related to sense of security: general anxieties about living independently (Sherwood and Morris, 1981), specific worries related to being a frail older person (an original scale), opinions about institutionalization (Zarit, 1982), and fear of crime (Patterson, 1978); (d) outcome

variables related to social contact: frequency and purpose of social interaction (an original scale).

The family interview encompassed the perceived condition of the EARS subscriber (health, activities of daily living, happiness), opinions about institutionalization, frequency and purpose of social contacts with the subscriber, and sense of burden (Zarit, Reever, & Bach-Peterson, 1980). The neighbor interview encompassed the perceived health of the EARS subscriber, and reactions to the role as emergency responder.

RESULTS

Background Information

While 60 pre-test interviews with subscribers were completed, at this time we have posttested and performed preliminary analyses of data from only the first 28 subscribers and a smaller number of family members and neighbors. Ten of the 60 subscribers are now deceased, and the remaining subscribers have not yet had their unit for one year. Consequently, these results are offered as an initial glance at our findings.

The age range of the sample was 54 to 99, with a mean of 78. Over three-quarters were women; over three-quarters were Caucasian; exactly 75% were widowed. The mean number of years of education was 11; about half of the respondents had an income of $4000-7000 per year. Over half lived in houses, and most of the rest in apartments; 15% lived with a family member, the rest lived alone. On the mental status exam, 73% scored in the unimpaired range, while the others were mildly impaired; 63% had noticed changes in their memory in the past year. Not surprisingly, their self-rated health status was poorer than national data for those 65 and older published by USHEW (1978), and 55% had fallen down in the past year.

On the Lifeline screening instrument, 47% met the criteria of group 2 (severely functionally impaired but not socially isolated) and 13% were distributed across the other groups. The remaining 40% did not fall into any of the screening groups; many of them were medically vulnerable but not socially isolated.

Slightly more of the family members were female than male, and their mean age was 54, with a range from 28 to 75. Among the neighbors, 70% were female, and their mean age was 62. Family members tended to live quite nearby (an average driving distance of 18 1/2 minutes), while most of the neighbors lived next door.

Expected Benefits

Before the units were installed, we asked subscribers and their families about the benefits they expected from EARS; a year later we asked what benefits had been obtained. At pretest, the two greatest benefits expected by the subscriber were an increased sense of security and the ability to obtain emergency help if needed. Others stressed that EARS alleviated their families' concerns about their living situation, and a handful mentioned the possibility that EARS might increase their independence and self-reliance and enable them to get out more. Two other variables that figured in subscribers' responses were the fact that they lived alone or were in poor health, especially having a history of falling. Some of the images were marvelous: the unit was referred to as like a "mechanical dog" or "like having a friend in the house." At posttest the greatest benefit reported was the sense of security, followed again by emergency help if needed, frequently combined with comments about the value of EARS for someone living alone. However, fully a third did not discern that having the unit made any changes in their life. Twenty-five percent of the subscribers attributed their getting the unit to their family's hearing about it, and at posttest 78% saw the unit as providing more peace of mind and independence for their family.

Families' perceptions of the benefits of having EARS also centered on an increased sense of security, both their own and the subscribers', and the availability of emergency help if needed. The second most often noted change was increased independence both for the family and the subscriber. The family felt able to get out more, and to see or telephone their aged parent less frequently. Over a third of the families in turn saw the subscriber as able to live alone more confidently and to get out (e.g., into the yard) and do more things.

Lifeline Usage

Over the year there were an average of .28 emergencies per subscriber, which is somewhat lower than previous reports. However, if we consider only those subscribers who met the criteria of Sherwood and Morris' screening groups, the average number of emergencies per subscriber per year was .43, which is comparable to the figure reported by the demonstration project (Dibner et al., 1982; Sherwood and Morris, 1981). The emergencies predominately involved physical illness or accidents--50% or more entailed falling; chest pains were second. One call involved feeling confused. Interestingly, in 25-30% of the emergencies, someone other than the subscriber (more often a family member than a neighbor) pushed the button to signal an emergency.

A partial compilation of just those false alarms that were recorded by the hospital on emergency incident sheets indicates 1.10 per subscriber per year. Most of these entailed the subscriber's failing to reset the unit, sometimes because of neglecting to turn off the timer when leaving town. In these instances, neighbors often were asked to respond; sometimes the hospital checked with a relative; and, rarely, the paramedics were called and broke into the house. However, one failure to reset indicated a genuine emergency in which the subscriber was very ill.

We also asked subscribers about emergencies they had had when they did not use the Lifeline unit. The rate per year was some 40% greater than the rate of actually using the unit for emergencies. The nature of the emergencies for which EARS was not used was similar to those for which it was used--falling, heart problems, panic attack. The main reasons given for not using EARS were (a) a family member happened to call or the subscriber phoned the family member directly instead of using EARS to summon help, (b) the subscriber wasn't wearing the trigger, (c) the subscriber didn't want to bother the neighbor, or (d) the subscriber didn't know whether to regard the problem as an emergency or whether to handle it herself.

Pre-post Changes on Dependent Variable for Subscribers

On correlated t-tests comparing the subscribers' pre and post score levels, there were some statistical trends but basically little change. Mean scores on selected variables are shown in Table 1. There was a slight improvement in self-rated health status. In addition, there were trends toward less concern about having a medical emergency such as fainting or a heart attack and less anxiety about what to do in the case of an emergency, although there was no decrease in general anxiety. On other measures, there were trends in both directions, e.g., less fear of violence but slightly more negative affect and slightly reduced estimate of the likelihood of remaining in one's present living situation over the next two years.

Comparisons of extent of change between socially isolated and non-isolated subscribers were made using independent groups t-tests between the two difference scores (post minus pre), which is equivalent to a repeated measures analysis of variance. As shown in Table 2, socially isolated subscribers decreased significantly in sense of mastery, while tending on the other hand to endorse fewer specific worries. These findings parallel Sherwood and Morris' reports of some paradoxical results for socially isolated participants, as if having the unit may increase the social isolate's sense of vulnerability.

Table 1. Pre and Posttest Mean Scores on Dependent Measures for Subscribers.

	Pre	Post	t(N=28)
Self-rated health status[a]	2.75	2.54	1.80#
Extent of health concern[a]	2.18	2.04	0.58
Positive affect[b]	3.38	2.92	1.63
Negative affect[b] (Bradburn)	1.30	1.41	-0.43
Affect-Balance[b]	22.08	21.51	1.93#
Sense of Mastery (Pearlin)[a]	14.35	15.24	-0.95
General anxieties about living independently[a]	24.02	23.23	0.82
Specific worries about frailty[a]	21.17	19.53	0.98
Probability of institutionalization[a]	1.19	1.23	-0.30
Likelihood of remaining in present living situation[b]	2.00	1.88	1.81#
Feeling about EARS[b]	4.42	4.57	-0.56

[a] low scores indicate a more positive response (e.g., less concern, more sense of mastery)

[b] high scores indicate a more positive response (e.g., more positive affect, more pleased)

# $p < .10$

Those who were included in one of the Lifeline screening groups were significantly worse at pretest on at least five of the dependent measures than those subscribers who did not meet the criteria for any of the screening categories. There was little difference in extent of change from pre to posttest, however; only a statistical trend suggested that those who met screening group criteria decreased in anxiety, while those who were less impaired may have increased anxiety.

Table 2. Pre-Post Difference Scores for Socially Isolated and Not Isolated Subscribers.

	not isolated (N=23)	socially isolated (N=5)	t
Self-rated health status	-0.26	0.00	-0.83
Affect-Balance	-0.65	0.62	-1.42
Sense of Mastery	0.52	3.33	-2.26*
General anxieties about living independently	-0.54	-2.22	0.62
Specific worries about frailty	-0.45	-8.50	1.77#
Feeling about EARS	0.17	0.00	0.26

#p<.10

*p<.05

Finally, there were virtually no differences in extent of change between subscribers who used their Lifeline unit in an emergency and those who experienced emergencies but chose to rely on resources other than their unit. This result suggests that the potential service of having the unit available may be as important a benefit of the system as its function in providing emergency assistance.

Pre-post Changes on Dependent Variables for Neighbors

Neighbors are an important link in the Lifeline system because they are called first in an emergency. Taken as a whole, they did not appear to be affected positively or negatively by fulfilling the responder role. At posttest they expressed the view that subscribers felt more positively about the EARS program and were less concerned about their health than at pretest (Table 3).

Pre-post Changes in Dependent Variables for Family Members

When asked directly whether they perceived change as a function of the EARS program, families saw more change than did subscribers. While only slightly over 50% of subscribers reported

Table 3. Pre and Posttest Mean Scores on Dependent Variables for Neighbors.

	Pretest	Posttest	t(N=10)
Subscriber's health status[a]	2.80	3.20	-1.18
Extent of subscriber's health concern[ac]	3.11	2.56	3.16**
Likelihood of subscriber's remaining in present living situation[b]	1.89	2.00	-1.00
Pleased with present living situation[b]	2.00	2.00	0.00
Subscriber's feeling about EARS[bc]	3.90	4.80	-2.59*
Neighbor's feeling about being a responder[b]	4.40	4.10	0.90
Interviewer's rating of neighbor's sense of burden[a]	1.80	1.90	-0.26
Interviewer's rating of neighbor's extent of involvement with subscriber[b]	2.80	3.30	-1.63

[a] low scores indicate a more positive response (e.g., less concern, less burden)

[b] high scores indicate a more positive response (e.g., more pleased, more involved)

[c] neighbors' indication of their impressions of the subscribers' feelings

* $p<.05$

** $p<.01$

Table 4. Pre and Posttest Mean Scores on Dependent Variables for Family Members.

	Pre	Post	t(N=20)
Subscriber's health status[ac]	2.75	2.90	-0.77
Extent of subscriber's health concern[ac]	3.20	3.00	1.29
Subscriber's positive affect[bc]	3.26	3.05	0.72
Subscriber's negative affect[ac]	2.61	2.05	1.78#
Subscriber's Affect-Balance[bc]	20.66	21.00	-0.71
Probability of institutionalization[a]	1.26	1.37	-0.49
Likelihood of subscriber's remaining in present living situation[b]	1.89	1.89	0.00
Pleased with present living situation[bc]	1.90	2.00	-1.45
Subscriber's feeling about EARS[bc]	4.25	4.35	-0.34
Family member's feeling about EARS[b]	4.90	4.75	0.77
Sense of Burden (Zarit)[a]	47.82	44.88	1.95*
Interviewer's rating of family's sense of burden[a]	3.55	2.55	3.45**
Interviewer's rating of family's extent of involvement in caring for subscriber[b]	1.80	2.05	-1.00

[a] low scores indicate a more positive response (e.g., less concern, less burden)

[b] high scores indicate a more positive response (e.g., more pleased, more involved)

[c] family members' indication of their impressions of the subscribers' feelings

# $p<.10$

** $p<.01$

having experienced changes because of the program, 80% of the families said that they had seen change in the subscriber. Yet, on the various scales that measure families' perceptions of the subscribers' happiness, health, and probability of institutionalization, there was little actual difference from pre to posttest (Table 4), only a trend toward seeing less negative affect in the subscriber.

A clue to understanding this pattern of results is found in that the families described themselves as feeling less burdened: There was an overall trend toward decreased burden on the burden scale; the item showing the most impressive change was a significant decrease in feeling angry toward their aged relative. The interviewers' ratings of the apparent extent of burden of the family also showed a significant decrease. Moreover, those families whose relatives used the unit showed a significantly greater decrease on the burden scale ($\bar{X} = -7.52$) than those families whose relatives did not use the unit ($\bar{X} = -0.27$), $\underline{t}\ (17) = -2.77$, $\underline{p} = .01$. In sum, several analyses converge to support the hypothesis that a major benefit of the EARS program and Lifeline technology is in decreased burden for the families of frail older adults.

We asked families as well under what conditions they would consider institutionalizing their older relative (Table 5). At pretest they were equally divided among saying that institutionalization would occur when the subscriber couldn't care for him or herself, when they were unable to obtain the necessary level of in-home care, or when the family was unable to do enough for their older relative. At posttest a new category emerged: fully 25% now asserted that under no circumstances would they consider nursing home placement.

DISCUSSION AND CONCLUSIONS

In summary, while we are presenting preliminary data and drawing occasional inferences from statistical trends, these results bear interestingly on the effect of a technological innovation on older persons and their families. For subscribers, in general there was little change, and benefit did not seem to depend on whether or not the device was used. Thus, the potential service of having the unit always available would seem to be as powerful an intervention psychologically as the actual use of the device in the case of an emergency.

The types of emergencies for which EARS was used were similar to reports from alarm systems elsewhere (e.g., Brenner, 1981; Dibner et al., 1982). Consistent also with previous reports (e.g., Brenner, 1981; Garrow, 1976), subscribers rarely used EARS for matters that did not require immediate attention. What was more often the case

Table 5. Conditions under which Subscriber Might Enter Nursing Home.

	subscriber		family	
	pretest	posttest	pretest	posttest
never, under no circumstances	25%	15%	0%	28%
when became a burden on the family; family not able to do enough; family decided it was best	15%	15%	35%	17%
when helpless, impaired, unable to care for self; last resort	40%	52%	30%	33%
when can't obtain necessary help (unable to obtain home help, can't cook own meals, etc.)	8%	7%	35%	17%
when it's a better choice; when can enter a desirable facility	5%	7%	0%	6%
never have thought about it	7%	4%	0%	0%

was that subscribers did not use EARS even though the situation could have warranted it. The reasons for not using EARS again are similar to reasons that others (e.g., Butler, 1981) have reported for not using an alarm in an emergency--the person called directly for help or did not think the need was urgent enough to involve emergency responders. Although these findings indicate that the system was not being misused, another observation of Butler's may pertain: He suggested that people sometimes used the alarm system when, although the emergency was genuine, other ways of coping with it were available. In our study, for at least a quarter of the calls, the emergency was signalled by someone other than the subscriber pushing the button. This fact may be an instance of the phenomenon identified by Butler, because presumably these individuals could have used the telephone directly to call for help. Alternatively, the family member or neighbor may have been demonstrating to the frail older person that the situation was sufficiently serious to warrant using EARS, or the individual may actually not have known where else to turn for help.

The most striking effect of EARS was found in the families of subscribers, who indicated feeling more peace of mind, more freedom, less sense of burden, and more commitment to maintaining their relative outside of an institution. We can suppose that the greater

dismissal of nursing homes as a possibility for their older relatives is reflective of their reduced feeling of burden. Given that the decision to institutionalize an older person often involves the family (e.g., Kutza, 1980; Linn & Gurel, 1972), these changes on the part of families become quite important. Consequently, families should be included in future studies of the cost-benefit of emergency alert technological systems.

A further finding was that the screening procedure proposed by Lifeline received support in predicting which subscribers were more apt to use the system. However, benefit did not seem to depend on whether or not the subscriber met the criteria of one of the screening groups. The distinction which emerged as being most salient was whether or not the subscriber was socially isolated. Consistent with Sherwood and Morris (1981), we found that socially isolated subscribers showed some effects opposite of those hypothesized--in particular, their sense of mastery declined appreciably.

In conclusion, EARS offers an example of how advances in technology can be employed to help older persons. Some (e.g., Sewel, 1983) have raised concerns that alarm systems represent a "technological fix" in the face of economic restraints and cuts in service provision. Along similar lines to our preliminary findings for socially isolated subscribers, Butler (1983) has expressed concern that alarm systems may at times unintentionally serve to undermine the independence of an older person. Moreover, he has suggested that the psychological support afforded by alarm systems may be more for the social providers than for the subscribers. Others (e.g., Dibner, 1982) have seen the technology as offering the older person another option, complementing other services in a long term care system. Our results suggest that effects for the family were possibly greater than for the subscriber, but that the psychological support afforded to the family may indirectly benefit the subscriber. Clearly discretion is called for in determining how much support to offer to the frail older person and in setting up a personal emergency response system such that it widens choice for older persons and their families.

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Appendix D

Draft of Selected Casebook Materials

Counseling with a Dementia Caregiver

Nancy K. Orr

The following case illustrates the various issues that can be dealt with in one-to-one counseling with the caregiver of a dementia patient. In this case, counseling sessions were held regularly with the dementia patient's wife over a period of one year. During that time, the patient experienced serious declines in functional abilities, which created problems in adjustment for his wife.

The model used for intervention has been described by Zarit & Zarit (1983), and involves identifying the specific sources of burden on the caregiver. The counselor then seeks to reduce burden through the use of three techniques, providing information about the disease and its effects on behavior, teaching the caregiver a problem-solving method for managing the patient, and identifying potential sources of support. In the beginning counseling sessions, it became evident that the caregiver, Mrs. Jackson could use the information and suggestions made by her counselor in a problem-solving way to manage her husband's behavior more effectively. She made some progress, but rather than getting a sense of relief, she reported feeling upset and stuck. While she was now managing problems better, the counseling sessions also brought into clearer focus the fact that she was losing the relationship she had with her husband. At a critical point in the counseling, she was not even sure he recognized her or was benefiting from her caregiving. By coming to terms with this loss, she was able to become an effective problem-solver again. This change came about gradually, developing from the context of the therapeutic relationship between the client and counselor, rather than from a didactic approach through which one might lecture the caregiver to accept her loss. This case also illustrates the

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problems caused by the excessive prescription of medications for dementia patients.

Initial Interview

Mrs. Patti Jackson is a 56-year old woman whose problems centered around her husband, Harold, who was 63. Three years before the interview, he exhibited an abrupt change in behavior, refusing to go into work, or even to phone in an excuse. He was taken to see a general practitioner who reported finding nothing wrong, but felt he might be depressed. He was then taken to a private psychiatrist who medicated him with Sinequan (Doxepin), an anti-depressant. Later, he was taken for a neurological work-up which revealed no evidence of a tumor, stroke, or cardiovascular insufficiency which may have caused his abrupt behavior change. He was thus diagnosed with "early senility." (This type of vague diagnosis has, unfortunately, been all-too-common, and leaves the family with little information or understanding of how they might proceed in the care of the patient).

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Because she was unsatisfied with the information she had received previously from the hospital at which Harold had been evaluated, Patti brought her husband to the gerontology clinic for an evaluation. At the time of the initial interview, Harold was still able to dress and care for himself, although he had become quite irritable. He expressed resentment towards Patti for taking him to the doctors. Patti herself felt the need for a better understanding of his problems, and how she might cope with them.

While Harold's family was informed about his condition, Patti was the only one who takes care of him. Like other caregivers, this had been stressful to

her. She had frequent telephone contact with the other family members, but did not solicit their help in caring for him. Patti also has two daughters who were away at college, but who knew about their father's condition. She felt it important that she protect them from seeing Harold in his present state, and thus did not turn to them for any help.

During the initial evaluation, the counselor raised the possibility that Patti might join an on-going support group. She expressed an interest in the group, but she also felt a need for one-to-one counseling. There were certain issues she did not feel comfortable dealing with in a group setting, and indeed, found them difficult to discuss throughout the initial counseling sessions.

Patient-therapist relationship: Patti was a client who would follow through with directives. Timing, however, was very important to her. The therapist recognized this and often asked Patti if she were pushing her too hard. Patti would frequently come into a session and report that there had been a crisis situation, but she had waited until the crisis had passed to contact the counselor. When asked why she would wait, Patti replied that it was important to her to try to deal with difficult situations on her own, and she knew that she really got into trouble, she could always call her counselor. This independence was sometimes frustrating to her counselor, but Patti was also not becoming overly-dependent on the counseling relationship for solving her day-to-day problems.

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The counseling process: Initially, counseling consisted of educating Patti about the disease her husband had, and dealing with some realistic problems. Harold was staying alone in the house during the day, while Patti was at work. At noon, he would go out to get lunch at a nearby senior center. While there

seemed to be no risk at this time of his getting lost, Patti occasionally came home in the middle of the day to find he had left the door unlocked. Patti and the counselor came up with a plan to leave a sign on the door as a reminder, and to find out if that would make a difference. Patti came back and reported that plan had worked (While memory aids w8ill not work in every case, they are worth trying, if the caregiver can view it as an experiment).

Another problem dealt with in the early sessions was the fact that Patti became irritated with Harold when he forgot to do chores around the house. When she reminded him he had forgotten to do something, he got upset with her, saying things like "You are trying to make me a patient." The counselor pointed out that he did not like to be reminded he had a memory problem. That is a very common reaction of dementia patients. As an alternative, Patti decided she would just ask him to do the chore again, as if she had not asked before. This plan worked better for her, and he no longer got upset about being asked to do the chores.

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One major issue was the information Patti had gotten from Harold's physician. She reported to her counselor that the physician had mainly described the problem as "getting older." With her counselor, Patti made a list of questions to ask the doctor, and she was able to get specific information, including that the diagnosis was probably Alzheimer's Disease.

These early sessions increased Patti's ability to respond to day-to-day problems, and she felt better about her handling of the situation with each success. But Harold's condition continued to worsen, and new problems were now occurring. Up to this point, Patti had viewed the changes in his behavior as part of the long-standing patterns of interactions between them, rather than as

caused by the disease. Throughout their marriage, Harold had been secretive, and had intentionally kept things from her. She viewed his recent changes in behavior as intentional, especially his forgetting and believed that he was not revealing his motives to her. She responded as she had done in the past before the onset of the disease, by rationalizing with him. Her efforts to help him remember or to get at his motives for forgetting only resulted in upsetting both of them.

Her difficulties in dealing with him came to a head when he no longer recognized her, insisting that he was in a hospital, and that she was the head nurse. She reported this behavior in counseling sessions and her counselor helped her consider why Harold's refusal to recognize her was upsetting and how she could respond differently. Her counselor pointed out that trying to rationalize with him and reorienting him to reality was not working. As an alternative, they discussed asking Harold where he really thought he was, and who he thought she was. This was very difficult for her, because she feared that he would confirm that he no longer knew who she was. She decided to take the risk, however, and asked him where he thought he was, and more importantly who he thought she was. She was shocked by the fact that he really believed that he was in a hospital, and that she was the head matron of the wing he was on. She then asked him if he was married, and when he said "Yes", she asked him what his wife was like. He proceeded to descibe her as a beautiful, kind, and generous lady.

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In retrospect, this incident represented the critical turning point in therapy. Patti had made an attempt to communicate with her husband on a level of acceptance of his thoughts and his world. From this step, she learned that

he was responding to her efforts in caring for him by perceiving her as his nurse, and most importantly, that his behavior was not intended to hurt or upset her. She was the "wonderful matron who took care of his needs in the fine hospital he was in." There were other times when he thought she was his sister Ruth (whom he had always been close to), and at times he recognized Patti as his wife. Although he did not always recognize her, she came to understand that his misperceptions were ways he expressed positive feelings toward her for the care she was providing.

With this understanding, Patti was able to progress again in dealing with day-to-day problems. The counselor once more began stressing the problem-solving approach to caring for her husband. This technique is best exemplified by the planning involved in an impending trip to Chicago for their daughter's college graduation. By this time, Patti was quite aware of the effects travel can have on a dementia patient. With her counselor's collaboration, she planned how to minimize those effects. First, she decided to stay in a hotel rather than with relatives. She felt it would be more likey that he be upset by the numbers of people he would come in contact with if they stayed with relatives. Second, she called various hotels in search of one with a room that was arranged like their own bedroom, to minimize the disorientation he would experience when he got up at night to go to the bathroom. Because she knew that he had always been fearful of buses, she planned for transportation via taxi cabs. The only situation she found unavoidable was that of the commencement ceremony itself. She knew it would be crowded, and it would be inconvenient if he decided he had to go to the bathroom during the ceremony. She brought this problem into session and worked through it with her counselor, discussing how she would handle the situation if it did occur. The trip worked out well, and he did not

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become upset at any point, but was annoyed by the crowd at the graduation. He did not seem to know what was going on during the ceremony.

Although Harold did not indicate that he was aware of his surroundings at the ceremony, later that Fall Patti overheard hiim telling a friend that he was so proud of his daughter and that he had been to her graduation. This example is remarkable because he did not seem aware of her graduation at the time. By treating him as though he was aware, Patti was able to provide him with a positive experience, despite his dementia.

Another instance of Harold's perceptiveness was noted in his reaction to his mother's death. His mother, 92, had taken ill, and Patti decided that she would tell him of it. His mother had always been the matriarch of the family, and she felt it would have been important to Harold to know about her illness. He exhibited a few signs of recognition, but showed no affect when she told him. His only comment was "Oh, Mama's sick...poor Mama..." The next morning he spent 15 minutes searching for his mother, something he had not done previously. His mother had died during the time he was calling for her. During his mother's funeral, Harold showed no recognition of the event. A few days later, however, Patti found him crying, saying "Mama's gone."'

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Patti shared yet another instance with her counselor. Despite his impairment, she and Harold went dancing one evening. Although the disease had progressed to a point where he had a marked gait, the dance steps were so well learned that he was able to perform the complicated steps he and Patti had danced together earlier in their marriage despite his impairment. This was quite remarkable in that it occurred in the later part of therapy, at which time the disease was already in its advanced stages.

Medications: As with many dementia patients, Harold had been placed on a schedule of medications, many of which were interacting. He had originally been on a combination of Haldol (Haloperidol), Mellaril (Thioridazine), and a variety of other drugs, including some to control the side effects produced by the first two. During the initial counseling sessions with his wife, she described his behavior as characterized by outbursts of anger and even violence at times. Although these medications are frequently prescribed for controling behavioral outbursts by dementia patients, large doses may actually increase the frequency or severity of these problems in some persons. When Patti went back to Harold's physician with a list of questions, she stressed her concern over the amount of medication, and the physician proposed a plan of reducing them. Her counselor then encouraged her to monitor his behavior by keeping daily records of the occurence of problems. She could then note any changes in his behavior occurring with the modifications in his medication schedule. She reported his behavior as improving remarkably in response to manipulating his medications. She also used the problem-solving approach to his keeping her awake at night. She increased the amount of activities he had during the day, and decreased day-time naps. This combination of increased activity and decreased medications greatly reduced his outbursts. By the 4th month of counseling, she had reduced his drug intake to 2 mg. of Haldol per day. She described his resulting behavior as strikingly more alert, and more aware of his situation. He had become more talkative, and resumed recognizing Patti as his wife.

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Alternatives in caring for her husband:

When she first came in for counseling, Patti could leave her husband alone at home during the day, while she went to work. After a few months, it became apparent that he could no longer safely find the senior center where he had lunch, and there were other times he wandered off from their home. As these changes occurred, Patti was building a fairly extensive network of formal support services, including help with housework, and some supervision for Harold. She had been considering the option of retiring so that she could spend all of her time with her husband. Caregivers often give up all their other work, social and leisure activities, and later report feeling resentful, or just simply exhausted from not having anything else in their lives. Because it is difficult to be a full-time caregiver, Patti was encouraged to try to continue working, while using community resources to maintain Harold at home. Guided by her counselor, she decided to explore the alternative of day care services first. Day care turned out to be an effective alternative for her for almost a year, allowing her to work, while being reassured that Harold was in a good environment.

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The issue of having a life of her own proved much more difficult for Patti. Even as she discussed the frustrations of her routine, getting up and seeing that Harold got dressed and to day care, going to work, picking up Harold, and then spending the evening tending to him, she could not take the step of arranging for some time for herself. She reported feeling exhausted and "burned out," but could not justify taking time for herself. One alternative that was discussed in the counseling sessions was to involve her daughters more. Patti, however, believed that it would be harmful or detrimental to them to get more involved in their father's care. Her counselor helped her develop alternative ways of viewing the situation, and eventually helped her reframe it in terms of

being beneficial to her daughters to contribute to their father's care. She also began to recognize the importance of preparing her daughters to care for Harold in the event that she was no longer able to care for him. In addition, she became aware of the emotional distance she created between herself and her daughters by not giving them the opportunity to care for Harold, which in turn contributed to her feelings of "being alone."

The changes Patti made came out of a process in which the counselor repeatedly asked why it was so hard for Patti to turn over some of the care to her daughters. Patti would verbalize her thoughts, and with her counselor, they developed alternative ways of viewing the situation. Eventually she was able to reframe the situation, that involving her daughters was beneficial to them. This process of asking gentle, but probing questions is described by Beck, et al., 1979.

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Role of record keeping:

The counselor attributed much of Patti's progress in therapy to her efforts and ability to do record keeping. She initially understood the rationale, and found it compatible with her vocational training as a teacher. As she continued with her behavioral tracking of Harold throughout counseling, she began to see patterns in his behavior. If there was a change in his behavior, she was able to pinpoint an antecedant of that behavior, for example, a change in Harold's medication schedule. On one occasion, he abruptly became very agitated, started talking incessantly, and began to exhibit outbursts which had not been present for quite some time. She could not find either medical links, nor situational precursors to this change. In retrospect, she and her counselor linked this change to a time during which Patti was extremely stressed by goings on outside

her relationship with Harold. He was in fact responding to her tension. Examples like this one demonstrated to her the importance of keeping records, and searching for idenfiable causes of behavioral disturbances, rather than automatically ascribing it to the dementia.

Outcome:

Harold's behavior eventually became more difficult for Patti to cope with, attempts to alter that behavior through responding empathetically to him, and through manipulating his medications, and through controlling is pattern of sleep. She could no longer control him. He had become constantly restless and disruptive, and had begun urinating i the heat ventilators and talking loudly in the middle of the night. The day care program also could not manage him. At that point, Patti decided to place in a nursing home.

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Patti was very comfortable with her placement of her husband. With her counselor's help, she could recognize that she had exhausted any and all alternatives to caring for her husband. She knew that she had done everything possible for Harold. She reported no guilty thoughts, and decreased stress.

In retrospect, the counseling process enabled Patti to provide the kind of help to Harold that she wanted him to get, without placing too much burden or stress on herself. As his condition deteriorated, she reached out first to formal services, such as day care, and later to her daughters for the assistance that she needed. She believed she was fulfilling an important obligation to him. While nursing home placement eventually occurred, it was done with the family knowing they had done their best. The positive experiences they shared together contributed to his well-being, despite having a catastrophic illness.

A Dementia Patient with No Family Support

Nancy K. Orr

Initial Interview:

The following case illustrates the problems of a dementia patient with no family support. It raises issues of the use of home assessment, problems in obtaining treatment for reversible causes of dementia, and especially, the vunerability of the isolated older person.

Dianne Thompson called in regarding her neighbor, Muriel Davis, age 78, who she was concerned about. During the initial phone conversation Dianne reported that over the last two months, Muriel no longer appeared to be taking care of herself or her apartment. Muriel was apparently unwilling to step out of her apartment, sleeping on her couch (rather than in bed), and has stopped cooking. Dianne arranged for in home meal service for her, but she was not sure if Muriel had been eating them.

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Dianne recalled that Muriel's problems began approximately two years prior to the date of the interview. She noticed that Muriel was losing her keys and was not able to find them, subsequently locking herself out of her apartment. About one month ago Muriel began to complain about people spraying things through her door. The pattern of decline was reported as gradual, although possibly more rapid during past six months.

The intake interview was conducted as a home visit, providing the counselor with an opportunity to assess Muriel's level of function in her own home

environment. The interview was arranged for Muriel by her neighbors. Muriel was not aware of the appointment prior to the counselor's arrival. Upon entering Muriel's apartment for the homevisit, the counselor noticed it smelled heavily of urine. She also noticed that the couch was quite stained, and suspected that Muriel was having difficulty with bladder control. Her kitchen was a mess, with garbage and insects on her counter. Muriel had also stored her curtains in the refrigerator. Muriel's appearance was unkept, and looked as though she had not bathed in a while. Her hair was dirty and had not been combed. Her mood was quite low, with inappropriate laughter and annoyance in response to questions during the interview. She tested positive for brain impairment on the Face-Hand test, displacing stimuli from her right hand to right cheek, and was untestable for the Mental Status Questionnaire. Muriel would, for instance, go off on tangents and answer with statements totally unrelated to the questions asked. The interviewer described Muriel as hostile to some extent, and often laughing inappropriately.

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She was not on any medications at the time of the interview, and did not report any sleep disturbance. As reported by her neighbors, she had lost a fair amount of weight, but Muriel did not know how much. Dianne said that Muriel complains of backaches, although she did not consistently admit to the pain during the interview. The counselor suspected that this pain could have been linked to her incontinence. (Subsequent medical assessments indicated her incontinence was linked to a severe bladder infection). According to Dianne, there was a possibility that Muriel had cancer in the past, but details of her medical history were not known. Both her vision and hearing seemed fair to good during the interview.

Muriel's social network consisted of her neighbor, Hessie, who did her marketing for her and took out the trash, the mailman who checked in on her, Mrs. Ray, another neighbor who wrote her checks for her, and Dianne, who kept an eye on her most of the time. While Muriel has a son and daughter, they both live in other states and have not seen her in over a year.

From the Muriel's behavior during the interview, the counselor concluded that she would not obtain a medical evaluation on her own. This evaluation was critical to look for possible reversible aspects of her cognitive impairment and incontinence. It was also apparent that Muriel needed supervision with eating, dressing, and personal hygine in order to continue living at home, but it was unclear as to whether she could financially afford services, since she had long since misplaced her financial records. Without a concrete financial baseline, she could not have an evaluation for the services she needed. Eventually, the counselor worked out a budget for Muriel with Mrs. Ray and Dianne. They calculated her finances as solvant enough to afford in home services twice weekly.

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Muriel was taken in for a hospital assessment by her counselor and her friend, Mrs. Ray. The evaluation initially revealed she was severly malnourished, dehydrated, had a bladder infection, and had lost a significant amount of weight. Treatment of these problems and continued evaluation of her cognitive symptoms were begun. to the hospital for the workup, Muriel appeared slightly agitated. A thorough workup for other reversible causes of her condition was negative. Tests for thyroid malfunction and vitamin deficiency were both normal. The CAT scan showed severe cerebral atrophy. From the

apparent pattern of decline and her performance on cognitive tests, Muriel was diagnosed as having Senile Dementia of the Alzheimer Type (SDAT). Her counselor, however, noted dramatic improvement in her mental status and behavior during her hospital stay, corresponding to treatment of the presenting health problems. While some cognitive impairment was still present, Muriel's speech was now clear and coherent. Her counselor also described Muriel as delightful to be with, while she had previously been hostile towards her counselor. Muriel was also placed on 2 mg.p. O., t.i.d. for four days without noticeable improvement.

When Muriel was discharged, the hospital staff social worker planned to refer Muriel back to our center since she was not within the limits of their service area. Her counselor had decided to arrange for in-home services. Because of her cognitive deficits, Muriel needed supervision in eating, dressing, and personal hygine in order to continue living at home, but it was unclear as to whether she could afford them if they were available. Unfortunately, a legal technicality made evaluation of her financial status difficult. Upon admission, the hospital staff asked Muriel to sign a form stating that her hospitalization was voluntary. Although she did not understand what she was signing, her signature automatically eliminated the 72 hour hold and declared her legally competent to make decisions. This also made her ineligible for protective services at that time. But since the hospitalization was voluntary, this process could not be initiated. Had she been declared incompetent the public guardian's office would have picked her case up and arranged for the services she required. But since the hospitalization was At this point her counselor called Muriel's daughter in effort to have her take

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legal responsibility for Muriel. Her daughter ,however, said that she was not willing to become more involved. In speaking with the daughter, the counselor discovered that Muriel had abandoned her family when her children were very young. Her daughter felt no obligation to take care of her mother, and could not understand why the neighbors who were providing her with care at that time could not continue to do so. While she did want whatever was best for her mother, she was not willing to take any steps towards getting more involved in caring for Muriel. She did, however, agree to "straighten things out" during her upcoming visit to the state, as strongly urged by the counselor. The counselor then turned to Dianne Thompson, Mrs. Ray, Hessie and the postman, the four people who were involved with providing care for Muriel prior to her hospitalization, in effort to make arrangements for Muriel's care upon discharge from the "hold."

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Without someone to accept legal responsibility for her, the only was Muriel could obtain the self care services she needed, it was necessary for the department of health to visit her home and verify her need for those services. Her improvement upon discharge was apparent, but she had to decline to her her state prior to the hospitalization. Muriel's impairment was once again to the level that she was not aware of her need for help with self care. When the evaluators visited her, Muriel told them that she did not need help caring for herself. While her apartment was more unhealthful than at the time of the initial home visit, the evaluators took her at face value and decided she did not need services. Her counselor was not legally eligible to serve as Muriel's conservator. Already having unsuccessfully attempted to involve Muriel's daughter, counselor petitioned for protective services at that point. After

months of exhausting all possible means to acquire in home services for Muriel, the Health Department went out to Muriel's apartment and declared it unfit to live in. By that time, it was once again infested with bugs and quite unsanitary. Muriel had once again gone back down to the baseline level of the initial interview. She was then admitted to the county hospital for the urinary infection, and then put through the same evaluations conducted at the previous hospital. Conservatorship was applied for, but Muriel's daughter took no legal steps towards its acquisition. Months later, Muriel was placed in a nursing home.

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Muriel's case illustrates the situation of the isolated dementia patient who was in need of in home services in order to continue living in her own home. Although her counselor made every effort to maintain her in her home, she could not arrange for services without Muriel's consent. Although it would have been appropriate, the Public Guardian's office would not step in. One year after her placement in the nursing home, Muriel was still not able to initiate the process which would obtain the self care services she needed.

Counseling an Impaired Client

Virginia Mullin

Introduction

This case is presented as an example of successful counseling of an older person with an irreversible brain disease. The elderly suffering from any kind of irreversible brain disease are typically considered untreatable by mental health professionals. In fact, therapists may view therapeutic change for aging persons with considerable skepticism regardless of the aging person's mental status.

Presenting Complaint

Helen Ray, age 73, was widowed thirteen years ago and currently lives with her 70 year-old sister. Helen's son called the Center concerning his mother's apparent brain disease and poor vision. Helen's son requested counseling for his mother who seemed to depend a great deal on her son for activity. Helen's son also requested a referral for a companion/helper service.

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Intake

Helen (age 73) presented as an alert, attentive, neatly groomed woman with an obviously slowed gait.

As the intake interview began Helen appeared hesitant, even frightened - tending to glance at her son for support and guidance during the questioning.

This initial tentativeness disappeared as the therapist attempted to provide the context of safety necessary to both relax and engage Helen. It became clear to the interviewer that Helen could answer most questions independent of her son.

It is important to note that the therapist adjusted the pacing of the interview to fit the special needs of this client. For example, Helen had word-finding difficulties (aphasia) a condition which required that the

therapist be especially patient and supportive in this information gathering stage. More specifically, the therapist assured Helen that she could wait, that Helen could take the time she needed to find the word. Together, the therapist and client developed this simple strategy to reduce the anxiety involved in word-finding.

Medical History

Helen is the older of three children. The family history shows that her parents are both dead, her father at 65 of heart disease, her mother at 32 in a car accident. The youngest sister died at 56 and one sister (who lives with Helen) is 70 and is a polio victim. There is no family history of significant mental or neurologic disease. Nor is there a history suggesting stroke or head injury. However, Helen's son reports very gradual deterioration of cognitive abilities in his mother for as long as eight years. In addition to this graduate deterioration, Helen suffers from a serious, though undetermined visual impairment which cataract surgery did not correct. Finally, Helen has a twenty year history of high blood pressure and obesity condition which are currently controlled with medication and food intake control. Medical records suggest that Helen suffers both from an unidentified kind of serious visual disturbance and a possible multi-infarct dementia.

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Psychosocial History

Helen lost her mother at a young age and was raised by her father and an aunt. Helen's father owned a small grocery store and Helen assisted her father in the business. At age 19 Helen met and subsequently married. She reported enjoying the process of raising two children, a boy and a girl. Specifically, Helen expressed pride in her children's academic and vocational (occupational) achievements.

When Helen's children were early adolescents, Helen worked as a legal secretary. Just before she retired Helen's husband died of a serious heart attack and Helen moved in with her sister. The current (new) living arrangement has worked fairly well though difficulties are reported. For example, Helen's visual and cognitive impairments make it difficult for her to perform household tasks. The burden of responsibility for these tasks rest primarily on her sister who is not visually impaired. This imbalance of household responsibilities and ineffective communication patterns interact to create unpleasant or hurtful scenes between the two sisters. Helen reported feeling uncomfortable about feeling overly dependent on her sister. More specifically, Helen can no longer cook on the stove because she cannot coordinate the burners and sometimes forgets to turn them off. Yet Helen wishes to make a contribution to the maintenance of the household.

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Helen's life history is suggestive of a person who experienced herself as efficient and capable during her early and middle adulthood. Nonetheless Helen appears to have a life-long pattern of shyness and dependency which currently manifests as a tendency to isolate herself from social situations outside the immediate family. Helen currently has no active friendships with the exception of casual contacts with persons who live in her apartment. Helen relies on her family for social stimulation as well as coordination of domestic tasks. She reported having great difficult interviewing, hiring, and subsequently utilizing, household helpers or driver/attendants. Further, Helen appears sensitive to mistreatment from family members. More specifically, in sessions, she described situations where she felt left out or unappreciated by individual family members. Where Helen was accustomed to serving as an important influence in her family, she finds it difficult to experience herself as a less than powerful influence.

Mental Status Exam

Helen's memory function, as tested by a brief mental status exam appeared to be intact if the disadvantage of the word finding difficulties were taken into account. For example, when asked "what kind of place is this?" she replied "a place which is going to help me." In addition, Helen was quick to offer the correct day and day of the week. However, Helen had greater difficulty with the Face-Hands test (a brief test of neurological functioning); she seemed to have most difficulty identifying sensation in her extremeties

Treatment Goals and Plan

The major treatment goal for Helen was reduction of feelings of low self-worth. Subgoals were the following: 1) to introduce Helen to the therapy process in order to increase psychological mindedness; (2) to help Helen improve communication skills, in particular, with family members and hired attendants; 3) to assist Helen in exploration of thoughts and feelings which related to her visual loss and to her impaired intellectual functioning; 4) to encourage Helen to experiment with a more active social life; 5) to help Helen reframe her negative thoughts and feelings about herself and others and 6) to provide Helen with the opportunity to gain insight about her physical losses and her family relationships. The treatment plan for Helen was individual therapy, once a week for six months.

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Psychological Mindedness

Helen was unfamiliar with the process of therapy. Early in the therapy she was encouraged to ask questions about the nature of therapy including discussion of issues of confidentiality and the issues related to setting the framework including time, place and fees. Helen began to notice the differences between the therapeutic relationship and a friendship. For

instance, the therapist was available to listen to her in a non-judgmental, empathic way. The therapist did not expect this process to be reciprocal. Helen was initially surprised and subsequently relaxed as the therapeutic alliance developed. Helen began to value such quality attention.

Communication Skills

The therapist noted that Helen was not clear in her communications with others, particularly with family members. She seemed to expect others to read her mind. When others failed to read her mind, Helen became sullen and withdrawn. Helen also tended to give double messages to her intimates, for example, pleading helplessness and adamantly refusing help. Together, Helen and the therapist worked to understand the results of these communication patterns. And Helen began to be aware that she rarely expressed her needs in a direct way, that she tended to manipulate others to get her way or to produce guilt, how she herslef typically ended up feeling bad about herself and even confused.

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Throughout the treatment period the client and therapist role-played key dialogues based on Helen's life situations. As a result, Helen became increasingly aware of her impact on others, in particular , how her indirect manipulations were not working for her. Additionally, the role playing process enabled Helen to release feelings, including embarrassment, resentment, sadness and amusement. Once she was able to express feelings she could form useful cognitions for herself to apply to her elations with others. One such cognition was: "I can let go of some of my resentment."

Working With The Impairments

Helen's difficulties with word finding clearly influenced the therapy process. Laughter was an important component with respect to this specific impairment. For example, the therapist joined with Helen in gentle laughter

when Helen was struggling to find a word or group of words. The laughter allowed her to release uncomfortable feelings, including embarrassment and fear. The therapist noticed that Helen, subsequent to laughing, had less difficulty finding the word and felt less inclined to apologize for her disability.

The freedom to laugh and to smile was evidenced when Helen shared her frustrations and difficulties walking, ambulating and seeing. Also, Helen was periodically reminded that she was taking more and more risks despite her physical impairments. For instance, Helen devised an ingenious way to dress herself (a difficult task, typically) and Helen felt positive about this accomplishment.

Helen and the therapist role-played monologues which Helen could use to introduce herself to persons uninformed about her speech and vision problems. "I might have occasional difficulty finding the right word - so I might need your patience" is one example of an introductory communication. This served to reduce the initial shyness and embarrassment experienced by the client in new situations.

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Social Life

At the onset of therapy Helen's only social stimulation was being provided by her immediate family. She expressed some minimal interest in renewing an acquaintance in her apartment building; this interest was periodically reinforced by the therapist. Helen was encouraged to explore her resistance to making new friends. Specifically, Helen perceived herself as poor company because she was physically disabled. Nonetheless, these periodic explorations in a supportive context led to Helen making several lunch dates with her apartment neighbors. Clearly these behaviors served to increase feelings of self-esteem

Reframing Negative Thought Patterns

Early in the therapy Helen reported her frustration at her inability to leave her apartment on her own. She would often phone her son and find that he was busy and therefore unavailable to take her out. Her son would suggest she phone the attendant/driver and Helen would quickly reject this suggestion. Subsequently, Helen felt neglected, depressed and a victim of her circumstances. Throughout the therapy, Helen was encouraged to explore alternate explanations for her son's "apparent" neglect of her. She began to notice her tendency to whine to her son rather than making her desires clear. Her son's temporary inaccessibility was viewed more realistically by the client, not as proof of her being unwanted or unloved. These new thoughts seemed to make it possible for Helen to willingly choose alternate sources of assistance. More specifically, Helen's early resistance to utilizing available homemaker/driver services was reduced somewhat, enabling her to leave her home more frequently. Consequently, Helen reported her relations with her son and other family members improved.

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Additionally, the therapist helped Helen develop a set of positive self-statements designed to encourage Helen to affirm herself and give herself positive directions. Helen learned to say to herself such statements as "I make important contributions to my family" or "I can remember things" or "I forgive myself very quickly when I forget a word."

At one point in the therapy Helen reported an incident where her son inquired whether she would prefer living in a nursing home. This inquiry and implied suggestion precipitated a mild panic and depression. The therapist helped her to re-frame her thoughts and feelings, to view the situation as an opportunity to plan realistically for the future as well as to express thoughts and feelings more openly. She noticed that she felt better when she let

herself think about her future in the therapy context; she acknowledged her own use of denial.

Insight

Despite this client's physical impairments and (just) developing psychological mindedness, she was able to gain insights for herself in the therapy. It was clear to the therapist that Helen attempted to integrate what she learned during the process. For instance, she would comment upon the process of previous sessions, noting that she was "thinking about things" during the interim. Also, she would periodically ask questions of the therapist, questions aimed at understanding herself, her past history and current life situations. At one point she needed to understand why she held on to grudges or resentments about her intimates or her attendants. She became aware that she, herself, was the one who suffered while she was not expressing her feelings of being hurt or criticized. She began utilizing this insight by attempting to express her hurt feelings as soon as they happened. Then she could realize that others could handle her negative thoughts and feelings as long as she expressed them in a non-blaming way.

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Helen made a series of critical remarks about her driver-attendant. For example, she felt annoyed, even repulsed, by her driver's obesity. The therapist encouraged Helen to explore why this condition might bother her. Consequently Helen gained the insight that she herself had lived part of her life as an obese person, that she therefore was reminded of this oppressive experience when she was with the driver attendant. This new awareness was quickly learned and applied to analogous situations.

Summary

Helen has been presented as a successful therapy of a woman with an

irreversible brain impairment. This client was able to increase her psychological mindedness while building both communcation and coping skills. Helen learned to identify dysfunctional thoughts and to re-frame negative thoughts. Of considerable interest was Helen's ability to gain and utilize insights about herself, insights which seemed to increase feelings of self-worth or self-esteem. The therapy was structured and specially designed to fit the needs of an intelligent, aphasic, partially-sighted older person. The therapist was gratified by this client's enthusiastic and cooperative spirit.

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A Group for Depression

Steven H. Zarit, Virginia Mullin and Shari Miura

Introduction

The prospect of doing structured group therapy with midly and moderately depressed older persons has recently been receiving increased attention. There are several reasons why groups would have potential advantages over individual psychoterhapy for depression. First, many of the problems of older depressed persons are interpersonal. Loneliness is a frequent theme, and a group offers an opportunity to interact with others. Furthermore, many depressed persons lack the social skills to develop new friendships or receive as much support as they might from existing friendships. The relation between depression; and social skills has been demonstrated in a series of studies (Lewinsohn, Biglan, and Zeiss 1976; Interpersonal therapy program). Because of the possibilities for role-playing and shaping new social responses, groups are an appropriate place for treating social skills deficits. Finally, groups can reduce feelings of isolations while creating opportunities for learning and helping others.

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Three structured psychotherapies for depression have been developed in recent years, Lewinsohn's Behavioral Therapy (Lewinsohn, et al., 1977), the Cognitive Behavioral Therapy of Beck and his associates (Beck, 1976; Beck, et al., 1979), and the Interpersonal Psychotherapy for Depression (Weissman, et al., 1979). The first two therapies have been used with some success with older persons (Gallagher & Thompson, 1981; 1983), and the behavioral approach has been adapted into a group format. The following is an attempt to utilize the cognitive-behavioral methods of Beck in a group setting.

This group also raises issues of the relation between disabilities of later life and depression. Participants in the group were all former patients at the Center for the Partially Sighted in Santa Monica, California. All of them had significant degrees of vision loss, which could not be correcred by ordinary eye glasses. The program at the Center for the Partially Sighted assists persons to enhance their remaining eyesight through the use of visual aids, which were used by all of the group members. These included magnifiers, and high powered telescopic lenses, and a closed circuit television for reading in the case of one group member. Interestingly, the issues raised by group members were not primarily focused on their vision impairment, because they had, to varying degrees, already come to terms with it. Rather, they raised personal and interpersonal issues that pertain to broader questions of adjustment. This experience illustrates the capacity of many older persons to overcome physical handicaps, and get on with the major concerns of their lives.

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A pervasive theme in the group therapy and aging literature is that all one needs to do is get a group together, and then something good will happen (Hartford, 1978). Group theorists, however, emphasize the importance of establishing therapeutic norms and utilizing properties of the group experience to promote change. (Hartford, 1978; Yalom, 1975; Lieberman, Yalom & Miles, 1973). The following group is structured both in terms of content, cognitive-behavioral methods of treatment are emphasized, and in terms of form, with the group leaders taking an active role in shaping group norms and process.

The Participants

There were originally 5 members of the group and two leaders (Steve, Ginny). A 6th person joined in the second session, but dropped out after the third meeting. All participants were screened by one of the psychologists at the Center for the Paritially Sighted for being a good candidate for the group. The criteria employed were that the person was sufficiently able to talk about his/her problems, could listen to others at least part of the time, and was moderately depressed.

The participants were:

James: James is a man in his early 70's, with the most severe vision loss in the group. He had suffered macular damage (loss of central vision, due to deterioration of nerve receptors or "cones" in the retina) in both eyes, and could receive only limited assistance from various visual aids. He had once been financially well off, but had suffered a series of reverses, and now lived on SSI. He was twice divorced and lived alone in subsidized housing in a dangerous part of town. He could not get out at night, unless he could prevail on an old friend to drive him around. He felt embarrassed, however, asking for help from friends, because of his reduced economic circumstances.

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Walter: Walter is in his late 70's. Walter is a very bright, articulate man who keeps up on current political issues, and has a biting wit. For instance, in talking about his vision loss, he says he is a "macular degenerate." Although his vision is severely limited, he is able to ride a bicycle and is ablw to read with the assistance of a closed circuit television. In addition to vision problems brought about by macular degeneration, he had been caring forhis wife for the past 12 years. She has

a progressive brain disease, probably a multi-infarct dementia. The strain on Walter was at times severe, and he had previously talked about his situation with one of the group leaders (Steve). During the course of the group, he will decide to place his wife in a board-and-care home. He has been depressed intermittently during the course of his wife's illness, and at one time was hospitalized for it.

Anne: Anne is a woman in her 50's, who had suffered diabetic changes (diabetic retinopathy) which affected her eyes, and also led to amputation of one foot. She is currently on disability because of the vision changes. She talks in a monotone voice, and hints at strong, complex feeling that underlie her placid facade. But she was never able to bring these feelings out in a more direct way. After the 10th session of the group, she was hospitalized for complications caused by the diabetes, and had a second amputation. She was still in the hospital at the time the group terminated.

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Betty: Betty is also in her 50's, and had vision problems due to diabetic retinipathy. Betty is married with 2 grown children. She has also increasingly taken over care of he rown mother, who is in her 80's and depends on Betty for certain things, such as help in getting to doctor's appointments. Betty's husband works long hours, and is not overly affectionate or considerate towards her. While she is not currently working, she had gotten a lot of positive gratification from work in the past, and would like to resume her career. She worries, however, that she might not be able to work or assist her mother if she loses the vision in her better eye.

Harriet: Harriet is a spunky woman in her early 70's. She has an active social life, which unfortunately, has become more restricted since she is unable to drive. Her vision loss is due to macular degeneration. She dislikes having to depend on people for rides. She is interested in finding a man she is compatible with, but is frustrated by the few men who are available. She is continuing individual psychotherapy for depression, while attending the group.

George: George only attended the second and third sessions. He presented difficult problems for the group. He did not listen well to others, and then would enter into his own long, rambling stories. When the other group members talked about their problems, George would give them the advice he had learned from a book. He presented himself as cheerful and in control of his problems. He came late to the two sessions he attended, and decided not to return after that.

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Group Structure

The group was originally planned for 10 sessions, and was to be closed, rather than allowing new participants to join at any time. After the 8th session, the members expressed interest in extending the group, and so it was agreed to meet another 5 sessions. At the end of the 15th session, participants said they liked the format of a time-limited, closed group, because they got to know each other well. They also had a stronger sense of committment than with a drop in group.

Session 1:

Attending: Walter, Harriet, Anne, James, Betty

Leaders: Steve, Ginny

The agenda for the first session was a brief statement of purpose followed by introductions. Each group member then followed by stating what they wanted out of the group. That was when Anne raised a concern she had. Ann said that she did not know the group would be this structured. Her problem is with unstructured situations, and she didn't see how a structured group would help her with that. Steve responded by saying there would be unstructured time and a chance to work on her problem, but she seemed unconvinced and maintained a glum expression throughout the session, speaking very little. She seemed the most depressed. The others were animated in comparison.

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During this period, Harriet described herself as having a life-long history of ups and downs, with the better she feels related to a bigger drop. She wants to learn to prevent that.

Betty talked of socializing with people as her concern. She specifically asked, "Can I communicate bad feelings to others, or will they then avoid me." Her concern is that while she gives to others, she is afraid of burdening them with her problems. Later she talked about other issues. She apears to react to what happened most recently, rather than to stay with one problem until she makes a change. It will be important to help her stay focussed on issues, and not let current crises take up all her attention.

James' concern was loneliness, especially at sundown when he feels trapped in his apartment.

Walter alluded to his wife's problems, but never mentioned them directly. Partly it is because some of the others know, and partly he is not one to let it out easily. Instead, he talked frankly about his vision problem and how depressed it had made him feel in the past. He believes he has overcome his depression partly through finding the Center and learning the important distinction between "partially sighted" and "blind". Finding visual aids which helped him was also important. He apparently has more difficulty with his wife's situation.

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Walter also made a couple of announcements--his advertisements. It is important for him to do that, because he seems more uncomfortable with the unstructured format. If the group members view it as showing off, or bragging, then we will have a problem. They need to see him as vulnerable, too, which means he needs to share his feelings, instead of giving advice.

Anne's goal, pertaining to her concern she expressed at the outset of the session, was learning how to work with unstructured situations, but did not give any specific examples.

After the introductory material, Steve presented the cognitive theory. The connection between thoughts and feelings were illustrated by showing how the same situation can be interpreted differently, resulting in different emotional reactions. For instance, the example provided by Beck et al. (1979)..... ****QUOTE FROM BOOK*** This was an intellectual exercise--it may not have much

value, except if it created a vocabulary to be used later. The group members did not relate it to their own experiences, even when they presented some examples of how their thoughts affected feelings. They remained skeptical, and a summary of the session might have addressed that. They do not, as yet, see the value of the cognitive approach.

The homework for the week was for them to keep an activity record of what they did each day and to estimate how they felt, whether depressed or not, on a 1 to 10 scale. Figure 1 shows the form they were to use.

--- INSERT THOUGHT RECORD ABOUT HERE---

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Their instructions were to complete only the first column (the activities they engaged in), and to note their mood that day. This is the first step to creating thought records, by making them aware of when they are feeling depressed. Once they are monitoring mood fluctuations more closely, they will begin to be able to identify what thoughts they are having at the time they are feeling depressed. In the presentation of the activity records, they all demonstrated sufficient vision to write things down. James appeared to have the most severe vision problem. When the question of whether anyone would have trouble complying ("what would keep you from doing the homework?") Harriet and Betty responded. Harriet talked about how she might forget and feared that she might get worse if she were to record the things that depressed her. Steve responded that many people have that belief, but it usually turns out not to be so. Instead, it may reduce depression, if anything. It was not clear she was convinced.

Betty brought up not liking to fill out forms, and noted her own background as a social scientist. She went on to discuss her concerns about confidentiality, and the leaders discussed how confidentiality would be guaranteed.

Concerning completing the form, Steve acknowledged that she did not like that kind of task, but stressed its importance. Betty then said she was reluctant to complete the form because it was not going to be a typical week for her. She is going to take a plane trip and mentioned her claustrophic fears when the plane is sitting on the ground. Steve assured her it was still good to begin recording (and it could have been added, this is an opportunity to look at other than routine events--a good way to get started). This process is an example of what Beck, et al., (1979) call cognitive rehearsal, which involves anticipating the problems clients will have in completing assignments.

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At the point she agreed to keep the activity record, the group then discussed her fears about the flight. She reported that she actually had a plan to prevent becoming fearful. Her husband will board first, saving her a seat on the aisle (they cannot pre-reserve seats). She will then board at the final call. Then, if the plan is delayed on the ground for a long time, she will ask the stewardess to let her leave. Steve praised her ability to generate alternatives and handle the situation. The ability to generate alternatives is a very important part of cognitive therapy.

At the end of the session, Ginny did an exercise of going around the room and having people say when they know they are not depressed. She gave the example of not putting a flower in her hair when depressed, and putting it in

when she is feeling good. A couple of people did not seem to know (e.g., Anne) or were vague about it. But it was a good exercise--revealing a little of how they view positive experiences, or if they even note them.

Miscellaneous observations: We did not find out how many of the group members knew each other from before. Most did, but that is important information for everyone to have. Ginny, in not working with the elderly before, talked softlythroughout this first session. We discussed that afterwards. Because of the background noise in the room, it may be hard for some members to hear her.

For session 2: Work on compliance with homework. Use some examples for problem-solving and introduction of cognitive principles. Hold off until the third session for presentation of cognitive distortions.

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Session 2

Attending: Betty, Anne, Walter, James, George, Harriet

Steve's goal for the group was to introduce a problem-solving approach. Problem-solving involves identifying when problems occur on the activities records, what happened right before (antecedents) or what the result was (consequences), and then generating alternative strategies. Steve began by reviewing the record keeping. Walter started by announcing he did not keep records, because his mood did not fluctuate. He did have summaries of two days last week. The main thing was that his wife was wandering out again, and he was not becoming upset by it. She returned safely each time. He has now installed a hook on the outside of the door to u[illegible] when he goes out. We talked about this later as an example of problem solving, and how it is not a perfect solution, but worth trying. He will report back on how well it worked.

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In response to Walter, Betty wondered if it was bad for him to suppress emotions when his wife wandered. Steve explained that there are some times when expression of feelings is good, and other times when it is not. This may be an important clue, however, to her own problem. From the perspective of Beck's cognitive theory, excessive expression of emotions is not therapeutic. The reason is that the emotions are sometimes based on inaccurate or distorted interpretations of events. Rather than focussing on emotions, Beck et al. (1979) direct the patient to identify thoughts or interpretations of events which triggered the emotions. They also note that some people will engage in what they call "emotional reasoning," which involves saying "If I feel this way,

it must be so." The patient who is guilty, for instance, will maintain it must be true if he/she feels that way. Again, the response from a cognitive perspective is that the feelings can be based on inaccurate inferences or interpretations of events, and that is what needs to be examined. Betty's comment suggests she believes in the value of getting emotions out, and based on observations of her, it seems to be her style. However,getting in touch with feelings in itself is often not sufficient to lead to changes. Rather, the goal of cognitive interventions is to look at what led to the feelings, and then to generate alternative ways of thinking and acting.

About this time, George entered. He is a new member, and there was a slight disruption as he got settled, and apologized for being late. He blamed it on the buses, and got a lot of sympathy for it. We continued going around the room on homework. James indicated the problems were, as he expected, when he was alone at night. He talked aobut going out with a friend one night, and feeling better then. One issue he raised had to do with accepting help. After his vision loss, he at first rejected offers from friends to take him out, and in some ways pushed them away. He viewed their offers as charity. But now he will not turn them down, nor does he feel it demeans him. Steve suggested this was a good example of how thoughts affect mood.

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Anne seemed in a better mood, and had done the homework. She noted only a few upsetting events, with her mood rated as 5 on most days. There was one 9 day, when she went out and had a good time.

Betty was pleased with how well she did on the airplane, and said the positive feedback she got the week before on her plan had helped. She went on,

however, to talk about problems while in San Francisco, especially about getting meals on a regular schedule. Her brother-in-law was either insensitive or unaware of the fact that she has to eat at regular intervals because of her diabetes. One evening, they had set dinner for 7:30, and then he re-arranged it for 8:30 on his own. Betty's schedule was off, and so was her blood sugar. We returned to this problem later.

At this point, Ginny said she would like to hear from George. He began a rambling discourse on his background, including that he had a stroke, which affected his vision, and he had been feeling sorry for himself for a while, but was overcoming that now. Reading the book: Why Bad Things Happen to Good People, had been a big help to him, and he expounded a bit on its philosophy. Ginny's turning to him was good, because it brought him into the group. He was not shy about presenting himself to the group.

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At that point we began focussing on problem solving. James, who had seemed shy, surprisingly went first. There was clearly something on his mind. It had to do with his bus trip to the Center. He said that it upsets him a lot when unruly kinds get on the bus, and then the driver does nothing about it. The thoughts he has about it are that they are undisciplined and rude, their parents have not raised them right, and the driver should do something to maintain order--the driver is the captain of the ship. He gets frustrated at not being able to do anything, angry, and then depressed. Ginny also pointed to the fact that it was a situation out of his control, and he agreed. We began problem solving by asking what he had considered as possible solutions. One thing he said was getting off the bus and waiting for the next one. With that, George

launched into a rambling story of his own bus trip to the Center, the point of which was that you needed to put bad things out of your mind. Ginny asked if James could do that, or it he had tried meditating, and he said he was unable to. George then started lecturing again, and Steve cut him off, talking about the difference between giving advice and talking about one's own experience. George was fairly quiet after that. (It is important to control rambling members, but without cutting off too much freedom. He had previously talked through Steve's attempts to cut his stories shorter. A positive way of approaching it is to point out he has a lot to say, that the group really seems important to him because it is an outlet, but that he has to take less time to allow others their choice.)

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Getting back to James, Ginny came up with the suggestion for him to notice when he stops being upset, and what has brought that about. Steve gave him that as his assignment. It was not clear as to whether or not to pursue this cognitively. The approach would be to look at "should" ---others should behave in certain ways. However, the problem may have to do with James' feeling of having no choice--he can no longer drive or afford other means of travel.

The last issue was Betty's. Actually, earlier while James was talking about learning that he did not have to be independent all the time, Betty noted she has the opposite problem: that everyone in the family depends on her, without regard to how she is feeling. Ginny picked that up and acknowledged it at the time, and after James finished, Steve came back to it, and encouraged Ginny and Betty to discuss it a bit. When working in a problem-solving format, the group leaders want to stay with one person, until there is some resolution.

At the same time, the discussion often raises important personal issues for others, as in this instance. The leaders, then, can table the new problem, rather than getting distracted by it, and come back to it later. The problem Betty raised was one she discussed earlier when talking about her trip, that of going out to dinner on everyone else's schedule. She describes being hesitant to put her needs forward, but then is angry or upset with others for not taking her into account. She told some stories of difficult situations she has been in, and talked about a couple who always insist on going out on their schedule. Betty will propose a time for dinner, and they will say it's too early, and then suggest another time. Steve gave her an example of persisting ("I'd really prefer it at such and such a time"), and also of reaching compromises between her schedule and other people's. But this is an important issue to return to. Her assignment was to keep track of invitations out. She appeared to like the assertive responses that were suggested. A related issue she raised, but which was not discussed, is how much about diabetes to reveal to others.

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Session 3:

Attending: Betty, Anne, Harriet, Walter, James, George

Steve briefly noted the homework, and no one reported problems in record-keeping with the exception of Harriet. She had done it the first week, but not the second. Steve suggested she had no feedback, because she missed the last session, so she probably would do it now. She then expressed concern that she had missed so much, and could not catch up or be a part of the group. Others said that was not so, and she asked to hear the tape from the week before (The group sessions were being recorded). Steve said he would bring it in, and encouraged her that she would feel a part of things after 15 minutes. (In retrospect, we could have come back to this issue later on to see if she now felt a part of the group, since that is an important condition for therapeutic change to occur (Yalom, 1975). As it happened, there was not enough attention paid to htis issue, an Harriet raised it again in the next sesion.

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Steve then stated the agenda for the session, to talk about cognitive distortions, and then come back to problem-solving. He went over the 10 distortions that Burns identifies in his book, Feeling Good (1981). (The group members had received a reprint from the large-print readers digest describing cognitive therapy for depression; and listing these 10 distortions. The 10 distortions appear in Figure _____.) There was little commment or reaction from the group during this presentation. At the outset, Walter raised questions about the concept of automatic thoughts--of how people could not be aware of a thought, and still have it affect them. Betty later thought that sometimes

"shoulds" were appropriate, such as a doctor telling her she should take insulin. Steve tried to give alternatives, and then said we could discuss it later. (The altenative is "It is in my best interest to take insulin." The consequence of thinking that way is to be more motivated, than telling oneself "I should."

For the rest of the group, we came back to the problems discussed the previous week. Steve started with James, who had a bad day on the buses yesterday. Steve tried to apply the cognitive approach to this problem. James said the problem was that all the kids on the bus were inconsiderate. Through questioning him, he clarified that, in fact, only 3 of them were actually carrying radios that were playing loudly. He could not see this as an overgeneralization and insisted the others could say something to those with a radio. Walter and Betty made practical suggestions--getting earplugs, or taking the bus at different times, and later the idea of getting his own walkman came up. He listened to these practical suggestions, but they did not lessen his anger. He noted that part of his anger is not having a choice about riding the bus. He is dependent on it, after having driven in the past. That seems to be a real key to his anger. The leaders assigned him for the next week to note on the thought record when he is thinking about his lack of options.

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Walter reported that placing a latch on the outside of his door had prevented his wife from wandering. Although he had gone out several times, she had not wandered off, nor had she seemed upset over the latch. Walter also felt the latch was not a safety problem, since a neighbor could let his wife out in an emergency. Steve noted this example as an instance of successful

problem-solving.

Betty's evening out had gone fine. She did not run into the problem she noted the week before of not having dinner early enough. She said the reason there had been no problem is that they had gone to a concert, and had to eat early, in order to arrive on time. She appeared to dismiss this example. Steve tried to get her to plan for future evenings out. Betty said she did not have any plans to go out in the immediate future and changed the subject. She said she had a hemorhage in her eye on Sunday, and was very worried about it. The other group members (all of whom have much poorer eyesight than Betty) responded by saying that if things do get worse for Betty she will figure out how to cope. She was concerned that [illegible] other did not know about her decreased vision, and depends on her for a lot, including transportation. Ginny assigned her to keep records of self-disclosure about her problems, and come back to talk about that. This was an example of Betty changing to what is most recent, and not following through on what she started. It was a compelling example, one that grabs attention. But her tendency to focus on what is most recent also prevents her from reaching any closure on a problem, or initiating any change.

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With time running out, Anne jumped in. At first she responded to Betty by describing herself as someone who may sometimes disclose too much. Then she talked about her frustrations and irritation with us. She said she doesn't like feeling as though she is not accomplishing anything in the session. Steve responded saying he had done too much talking in this session, by presenting information on cognitive distortions, and there would be more of a chance for her and other group members next time.

Session 4:

Attending: Betty, Walter, James, Anne, Harriet, Ginny & Steve
George was missing and had called to say he wouldn't be there.

Harriet began the group by saying she was angry with Steve, and felt left out of the last session. The reason was that he had promised her the tape of the session she missed, and then forgot to bring it. (He had it this week). She then got to feeling more and more left out as other people talked. James was noticeably involved as Harriet discussed her reactions. He nodded and gave other non-verbal indications of his concern. Steve told her he was glad she brought this up, as it was a good example for all of us to learn about cognitive therapy, and because she was upset. He brought up the notion of alternatives. Alternatives is a procedure used by Beck and his associates (1979) to change exaggerated and dysfunctional thought patterns. It involves encouraging clients to generate other possible ways of viewing troubling situations, and to consider the extent to which those interpretations are plausible alternatives to their original thoughts. In this case, Harriet said, that she was thinking Steve had left her out and forgotten the tape because he was not interested in her. When asked about alternatives she readily came up with several--too busy, etc. She then wondered if it was petty to bring this up, and the group assured her it was not. Anne brought up a situation where she felt she should have talked sooner in a group. By not talking, she apparently got left out later on. Harriet then talked about how it makes her feel vunerable to get upset and then show it. She was worried about what people would think of her. James, Betty, Anne and Ginny validated Harriet's courage to share hard feelings with the group; everyone seemed to get involved, listening well. Steve said he thought she was strong to bring it up (and to come back to the group, because she had thought of not coming.) James affirmed that,

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as well.

Betty picked up on something Harriet said about being vunerable by what you reveal to others. She started to talk, and then said she wanted to hear from Anne. Anne deferred back to Betty. It is not clear why Betty was trying to include Anne at that point, and speak for her. As Anne had been fairly quiet, it was an appropriate point to bring her into the discussion.

Betty then talked about her problem in telling people about her vision, and that one of the few friends she tells, a woman she sees frequently, does not seem interested. She had told her friend about her recent hemorhage. When she saw her friend again, the friend did not ask Betty how she was. Betty took that to indicate she cared more about her friend than her friend cared about her. Steve asked about alternatives. The group generated: her friend forgot, she is insensitive, her mind was on other things, or that vision problems make her uncomfortable. We then talked about how Betty might approach her. Steve suggested "Does it make you uncomfortable when I talk about my vision." Betty liked that. Ginny also suggested saying that Betty valued her as a friend.

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From there, Anne began talking about not being accepted for a peer counselor program. She had difficulty speaking out in their training group, in contrast to the way Harriet had earlier been able to express her feelings. Anne, however, was quite elliptical in her comments and it was not clear if she was upset. She seemed to be saying that this other group's judgment of her ("detached, not enough emotion in her voice") was accurate, and maybe she did not fit into their group well. This was not stated clearly, and at the same time she was saying the group leaders had not made a

good judgment, since she could have become a good counselor. She believed she could have spoken to the trainers about their evaluation of her, but had failed to do so. Steve responded with empathetic statements, trying to figure out what she was saying. She puts up a front, which seems to say: Handle with care, and her agenda is never clear. But she talked for a long time. At the end she used the word "detached" and we seemed to hit on a possible agenda item: Being less detached when she wants to be. Steve did not say that detached was bad. Instead, he said sometimes it is good, and sometimes not, and the thing to work on is being less detached when you think being detached is a problem. It would probably be a mistake to want her to perceive us as being after her defenses. Rather, she needs encouraging to change in a direction she wants to go. She also talked somewhat about health--e.g., facing kidney problems, and also the frustrations of the vision exam she had earlier in the week when her optometrist could not give her a straight answer about whether she could pass the driving exam.

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When Anne reached the conclusion that the problem was being too detached, Harriet responded that her problem was being the opposite. Steve responded that their problem was the same: the qualities of being detachaed or emotional were not bad, but they each needed to work on being different in situations, where they wanted to act differently.

As time was running out, Walter talked about how he was really quite even, with no ups or downs. He mentioned that he had hired someone to stay with his wife on Monday, since he had to be away for most of the day. This experiment had worked out. He expressed concern that he would have to place her in a nursing home soon, and the group responded by questioning him that wouldn't it be better if he just

hired someone more often. He gave them the answer he had given Steve in the past before the group started: It is OK to hire someone when he has to go somewhere, but he cannot justify doing that when he has no place in particular to go to. Walter also noted that he had been more direct with his son about his wife's current condition. He is amazed and pleased with himself for taking these steps, and for his overall attitude these days. Everyone offered some kind of support to Walter.

As we were breaking up, James, who had been attentive, but quiet, said that he had taken one of our suggestions about the bus--the one that did not cost any money. He was riding the bus at different times, thereby avoiding the school kids that way. This had worked out well for him.

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After the group the leaders reflected on how much everyone had to say, and Steve resolved to start the next group on time, rather than several minutes late.

Session 5:

Attending: Walter, James, Betty, Harriet, Anne, Steve, Ginny
George was absent

We began by setting dates for December meetings, and will not meet either December 23 or 30th. Instead, the last two meetings will be in January. Anne thought Ginny said she would not attend after the first of the year, and expressed concern about it. Ginny explained that she could not make December 23, and she would be there after the 1st of the year. Steve mentioned that we would evaluate the group in those last two sessions to see if it would continue, and in what format.

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Betty began by saying she saw the value of cognitive therapy, but it did not appear to work for some issues, especially with respect to illness. She has been worrying about going blind, and views this fear as always hanging over her head. Harriet talked about taking each day at a time, and Betty said somtimes that works for her, and sometimes it does not. She brought up how her loss of vision is tied to a lot of other problems, e.g., being able to care for her mother, feeling productive, and not being able to exercise, which helps her when she is depressed. The other members talked about how when they got to the point where they had significant vision loss they learned to cope with it, and were even surprised by how well they did. Walter, for instance, rides a bike to the sessions. Betty had noted that they were all doing well. We ended with the suggestion of taking one problem at a time when she gets down, not running them all together. We also talked about how the accumulation of problems, as she has had in the last year, makes someone more vunerable to depression. The cognitive model aims at taking the edge off depression brought about by those problems. Walter noted that as the part we do to ourselves.

Betty liked, or appeared to like that formulation.

Walter then talked about his wife, and how he sometimes doesn't see the point of going on. We explored why he continues, and it turns out he feels a commitment to her, and wants to care for her at home. He said if she gets incontinent, then he would place her in a nursing home. If it came to that, however, he did not know if he could afford nursing home care for long. He does not want to hide assets, or to divorce her. (If he were to divorce her, he would be able to protect one half his assets, the rest going to pay for her nursing home care. When her money ran out, she would be picked up by the Medicaid program). We talked about the possibility of Medicaid covering her, but he said his pension is too high, even if he has no assets. Steve said he would explore this, and see if it was so. Walter got a lot of support from the group. At times he was tearful. But he appeared to be comfortable talking about his problems.

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Harriet had brought up the problem of loneliness while Walter was talking, and James had said that was his major concern as well. When Walter finished, Steve returned to the topic of loneliness. (Without direction from the leader, the topic might have gotten lost. But pursuing it was delayed until Walter had received feedback on the issue he brought up.) James did most of the talking. He said he was most upset at night, and couldn't even go for a walk, because his neighborhood was too dangerous. Walter suggested the "Y" might have a use for volunteers at night, and would even arrange transportation for him. He liked that idea, and said he would call. He said he has a lot of energy, and almost wishes he had less. He is very active most days, riding the buses to activities, and going for walks. Most days are solitary, except for his groups, and he indicated (but later denied) that he feels a

little better if he is with people. He said he feels good after Thursday's group meetings. Steve suggested more day time activities as an alternative, but he did not like that. He did say he could work in a friend's real estate office, but is afraid no one could read his writing. The group members looked at his writing, and thought it was good. He then said he could not read the listings book, and Steve suggested seeing if the Department of Vocational Rehabilitation would purchase a Closed Circuit Television for him. (The CCTV is a high-powered magnifying system that enables many partially-sighted persons to read print). He will call a resource counselor at the Center for the Partially Sighted to check it out. He did not like the suggestion that his friend's office rent it for him. Steve also suggested he come in to the Center to find out if he could use one.

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Anne slept, or appeared to sleep through the latter half of the group. The leaders need to focus on her next time. Ginny mentioned to her before the group ended the article that appeared in the newspaper about training peer counselors. It appeared the day after she talked about being washed out of the program. Anne said she had worked it out in her mind, and even made a donation to them.

Session 6:

Attending: James, Walter, Harriet, Anne, Betty Steve, Ginny
George was missing again, and has presumably dropped out.

Before the group Walter took Steve aside and asked a question. He wondered if Steve had said that placing his wife in a nursing home would shorten her life. This referred to a conversation they had before the first group. Steve had said that when placement becomes necessary, it is usually in the later stages of the disease. Walter was relieved with the explanation. Walter had made the same misinterpretation several months back,, when a similar conversation occurred

Steve opened the group with Walter, and with the information he had for him about Medicaid. It would pick up his wife's nursing home costs, but only if he exhausted his own finances. He had come with his own plan, which involved getting a part-time job. He felt part-time work would allow him to make ends meet. He has an appointment with the handicapped counselor at the State employment agency. He also indicated he is ready to institutionalize his wife. Steve offered him support or help, if he runs into any problems. He became tearful while talking and said he is worried he will get depressed and suicidal if he does not place her. The group was quietly supportive, but not as demonstrative as in previous sessions. In general, the group mood was subdued all through the session.

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From Walter, we moved to James, for whom Steve had obtained information about CCTV's. The Department of Vocational Rehabilitation will no longer purchase them, but it is possible to buy used machines from the manufacturers. James reported that he had looked into working at his friend's office, but the real estate business was so poor that it was the first time in over 30 years that his friend had nothing in

escrow. So there was no work there. James also got the run-around from the "Y" on volunteer work. He appeared to take these disappointments in stride. (In retrospect, the group might have focussed more on his reactions, whether he had become depressed or had been able to accept disappointments without making things worse than they had to be). In general, he seemed in a good mood, and talked about the nice Thanksgiving he had at a friend's.

Betty mentioned a former student whose life was all messed up when Betty knew her, but who called rcently to say she had been able to make major changes as a result of going to a cognitive therapist. This was interesting, because the week before Betty had been saying she wondered if cognitive therapy worked for some problems. Anne then asked what the middle column of the thougnt records was for. Steve responded by saying we had not worked with it much, and then explained the thought column is for the assumptions or evaluations we make about a situation. Often, these are automatic--that is, we are not aware of them. These thoughts lead to the emotions we feel, whether fear, depression, or happiness. In the cognitive model, it is how we think about ourselves or situation that determines feelings. Anne then drifted off, making some elliptical statements about herself. They had to do with doing things for others as opposed to for one's self. She talked about getting over her deep depression last year, and believed that getting active did not make the difference. Instead, she saw her depression as just ending. It was never clear what point she wanted to raise about balancing activities, and she spent some time trying to shift the conversation to Betty, in order that Betty might about the amount of time she does things for others. Betty responded that doing for others, including her mother, makes her feel good. Anne talked about how her mother was

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independent until her death, partly through Anne's encouragement. Betty also gets into trouble bending too much for others, but we did not get into that.

With about 15 minutes to go, Steve turned to Harriet, who had been looking morose for most of the group, and who had added little. (In retrospect, this might have been done earlier, but the agenda was to give feedback on information to James and Walter, and then to try to reach Anne, who had slept through the previous session). Harriet was wrought up over the upcoming visit of her son. Rather than calling her to arrange the visit, he had called his brother. Harriet views this as rejection of her, and would not consider any alternative interpretation. (It retrospect, this was a good example to use the thought record.) She then talked in a rambling way about being rejected by her [illegible] She said she and Randall (the one about to visit) had been close in the past, but since his last marriage, they have been distant. He does not write or even return her calls. Steve suggested calling him to make the plans, but she rejected that, saying that would only confirm that he was rejecting her, and would be too painful. Her other son visits only once a month, when he balances her checkbook. Harriet and his wife do not get along. As Walter started to leave (and we were getting nowhere with Harriet), he made a little speech, saying she should tell the son--"This is it, you can visit me at such-and-such time. Take it or leave it." The group liked Walter's assertiveness, but Harriet appeared unmoved. We agreed to talk about it next time.

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Session 7:

Attending: Walter, Harriet, Anne, Betty, Ginny and Steve

Absent: James

James had called the Center to say he would not make the session. Later after the group, Steve called him, and found out he did not want to take the trip in the bad weather, and also had a cold.

Before the group started, Walter apologized to Harriet for being so direct at the end of the last meeting, and she acknowledged his apology. He then asked jokingly if she had done what he suggested (telling her son when she would be available to see him, rather than leaving it the other way around). She had not done that, however.

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Steve talked about the issue of giving and receiving, which had been raised in the last session. He said that it was particularly important in a group, because they are in a position to give support to one another. Betty responded by saying how good she feels giving to others, and Harriet said she used to feel that way in the past, but can no longer do what she used to, and wonders where all the volunteers went. She says there is no one to help her out when she needs it. Steve pointed out how special it is that they were volunteers, that it is hard to find someone who helps. Harriet then talked about her disappointments with her friends. She says she feels bitter and angry about how two friends in particular have treated her. The three of them had previously gone on vacations together, but since she suffered the vision loss, Harriet has not been invited to join them. Steve began to do a thought record of Harriet's interpretation of this situation. Harriet said she believes her

friends assume she does not see well enough to go on a vacation, or that she would be too much of a bother to take along. Steve identified that as mind-reading, and pushed to see if she would check that out with them. She insisted that she knew it, and there was no doubt in her mind. We went around on that awhile, and she got a bit angry with Steve. She finally said she believed if she forced the issue,, maybe she would find out that they really did not like her, and it was better to leave things as they were. As evidence, she reported that one of these friends had mentioned an upcoming trip to Hawaii, and Harriet had hinted she would like to go along. When this woman replied by saying she would ask their other friend if it would be all right for Harriet to come along, Harriet said she did not want to go, and wistfully added she would find someone else to travel with. Steve wondered if Harriet might have given them the impression that she did not want to travel with them, but she did not believe that to be so. Finally, Betty stepped in, and talked about redefining the relationship as an alternative way of approaching the problem. Harriet said that she does not drop them altogether, because they fulfill some needs for companionship. Steve suggested she view the situation as "I am disappointed about the change in our relationship, but there are still some good things I can get out of it." She seemed a bit skeptical (and also said she was already doing that). She was also talking about what she wants from friends, and one thing is to be able to get angry. Steve used that to say he was glad then that she could get angry at him, and she said she trusted him.

DRAFT

Betty then reminded us of the incident where she felt slighted by her friend, who did not ask her about the problem she was having with her eye. Betty said that it was Harriet who came up with the suggestion for asking if talking about her eye

problems made her friend uncomfortable. Betty said she tried it, and it worked well. In fact, it turned out her friend had been having some personal problems, and had been preoccupied. Steve used that as an example of testing out when we draw conclusions about what someone else says. Betty again noted that it was Harriet who suggested it, and we all agreed it was easier to make suggestions than do them, but the group felt Harriet was on the right track. We ended an agreement to discuss in a future session when and how to confront someone. Everyone appeared interested in the issue.

At this point when the discussion was about to drop, Walter revived it again with an attack on Harriet. He said maybe what we had was a recurring problem, and noted the similarity to Harriet's comments last week concerning feeling bad about one's self because of being handicapped. Walter felt this issue was the key, because we then projected that feeling onto others, who then treat us as less than equal. Steve tried to get Walter to focus on his own experience, instead of attacking Harriet, and he talked about having been in a mental hospital several years back after his eye problems first started. Harriet then mentioned how a friend had helped her recently to deal better with her vision loss. Her friend told her that because she now had difficulty seeing, other people no longer knew how she was seeing them. As a result, it made them uncomfortable. She credited this as a great insight, and decided that she should approach some of the people at Church who have been avoiding her. Steve saw that as a very positive sign, something to follow up on in the future sessions as a way of helping her be more direct.

DRAFT

At that point the group seemed drained of energy, and adjourned a little early.

Session 8:

Attending: Steve, Ginny, Walter, James,, Betty, Harriet, Anne

The group began by welcoming James back, and then turning to Harriet to see if she had worked things out with her friends. She said she had done better during the week, and in fact, looked at her two friends differently. She saw her relationship with them as limited, and could accept that. She also recounted that she had a positive meeting with her son and his wife. She said she was direct with him about making arrangements with her next time he visits, and not through her other son. She did this at the end of a pleasant visit, and he agreed with her. She seemed very pleased at how the visit went.

DRAFT

Betty talked a lot about the difficulty of letting her mother know about her eyes. She recounted the frustration she had been experiencing when she recently took her mother to doctors' offices. They had to wait a long time. While they were waiting, Betty felt she could read, because she would have to use a magnifying glass, and that would let her mother know she had a problem with her eyes. The group encouraged her to let her mother know, and even pointed out that her mother probably knew already. Harriet encouraged her to be direct (interestingly, in ways she had trouble being direct). We talked about telling her mother that her vision had changed, and the magnifier now helped her, but without going into details about the hemorhages she has suffered, or that she might go blind. She is considering doing that, but her mother may be facing some eye surgery herself, and so she (Betty) does not want to worry her more.

Betty also talked about feeling responsible for her mother, especially that something bad might happen. Her mother lives alone in a canyon, and Betty worries about her. We talked about how important it was for the quality of her mother's life to be good. Her mother likes the house and gardens all day. Betty said she feels guilty when she goes out of town and it is difficult to find someone to check in on her mother. Her mother, from Betty's account, wants to be independent, but it is Betty who is worried that something bad might happen to her. We talked a little about that as a risk she is willing to accept, in turn for maintaining the quality of her life. This issue seems very important for Betty, and the group should come back to it at a later time.

James talked about a disappointment, that [illegible] friend died, and left very little to him in his will. He also had given his [illegible] some money to invest, but there was no note or record. Unless the lawyer handling the estate comes across a record, James will be out his money. He is upset, and stays up at night worrying. The group had some practical suggestions (e.g., he can be present when the safe deposit box is opened).

DRAFT

Walter did not talk much. He did say he is waiting until his son visits in January, and then after that he will consider placing his wife in a nursing home, or board and care.

Anne talked for a bit in her usual way, with little emotion. She spoke again of no longer being depressed, but it is not clear at all what is going on with her.

Session 9:

Attending: James, Walter, Betty, Harriet, Steve, and Ginny

We spent much of the session on assertion training. Virtually all participants had mentioned having problems that could have been avoided had they acted more assertively. Harriet's interactions with her son and friends were the most recent examples. These interpersonal situations were frequently noted by participants as antecedents of strong depressive feelings. These feelings, moreover, arose from typical depressive thoughts. In Harriet's case, she seemed to be saying: "If I really found out the truth about how people felt about me, I would be devastated. I'd be even worse off than I am now." Betty, likewise, seemed to fear that people were rejecting her, or would not want to accomodate to her. James was mainly upset that the world was not a fair and just place. Walter and Anne, while giving examples when they might have done better if they had been assertive, had not revealed much about how they interpreted those situations. Assertion training created the opportunity to shape new behavioral responses to improve social interactions, while continuing to examine the depressive themes participants had been identifying. The session began with definitions of the difference between assertion, passiveness, and aggression. The leaders then read examples from Lange and Jakubowski (Responsible Assertive Behavior, Champaign, Ill.: Research Press, 1976). Group members could identify the examples as assertive, aggressive or passive. The one exception had to do with getting a ride. One person requested a ride, and the other refused, saying instead she could take her friend part of the way to a bus stop. Harriet reacted strongly, by saying "Well, I would go with her to the bus stop, and then call a cab." She clearly was upset over the refusal, even though it was made graciously. Asking for rides is very difficult for her, and she finds it hard to accept refusal. She was also too adamant to pursue the issue at this time.

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Each person then gave some appropriate personal examples of assertion. James talked about turning down a New Year's Eve date because he was feeling ill, but the woman was clearly annoyed with him. We discussed that he had done it well, even though she took it badly. So far his efforts to patch things up with her have been unsuccessful, but he believes he was right to say "no."

Walter gave an example of aggressiveness, telling his daughter and son-in-law off for the perceived lack of help they have given him in caring for his wife. He appeared from his retelling to have been quite angry, but he also let them know what he wanted from them (as opposed to what he expected them to understand he needed).

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Anne is in the hospital, facing a possible amputation. Group members took down her number and planned to call. Before this session, Ginny and Steve had discussed their impressions of how far the group had gotten and both felt participants were just beginning to make progress on their problems. It was decided to suggest adding another 5 sessions to the group. Betty and Harriet were enthusiastic about the proposal. Walter and James were not as enthusiastic, but were definitely willing to cintinue. It was decided, therefore, to meet for another 5 sessions.

Session 10:

Attending: Walter, Betty, Harriet, Steve & Ginny.

James could not be there.

The group continued to discuss assertion issues. Harriet began by talking about an experience in which she was chairing a meeting. Since she could not see people who wanted to talk, they all started talking at once. She came up with a plan to respond to them next time, by saying they had to get her attention before they talked.

Most of the session was spent discussing Betty's problems with assertion, especially towards her husband. She discussed two issues, he comes home late without calling, and he did not give her a gift for their anniversary. Ginny did some role playing with her. She suggested the assertion was related to resentments Betty has about the relationship. Betty largely feels he does not give her time or attention, while she goes out of her way to do things for him. She sees how she could be assertive, but does not think it would change his behavior. She also does not want him to get upset or guilty if she says this to him. We talked about how being direct at least would let him know what she wants, and it might help her, even if he doesn't change. Role playing was used to let her try out different responses, and she enjoyed it. She has been more direct in asking him to phone if he is late, and that has worked out well.

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After talking for some time with her, she then shifted the conversation to Walter and his situation. He said that after his outburst one week ago his daughter was now more responsive, calling frequently, and had made arrangements

with a Board and Care to take his wife. He tried to shift the focus back to Betty, giving her advice (tell your husband he can be home by a certain time, or can stop for dinner on the way home). Walter did not see his own problem in being direct. Steve tried to make the point that everyone has problems being direct with the people who are closest, and that he had problems with his daughter. He blamed himself for that. (The leaders should have examined that belief).

The group was fairly animated, even though only three of them were there. Betty especially put a lot of energy into talking, but it appeared from her response to suggestions that she did not see much hope for change.

DRAFT

We also talked about the fact that we expect other people to understand what we want, without saying it directly. Harold brought this up, when discussing his daughter. Everyone agreed, which seemed a major step forward from previous discussions in which the group members brought up situations where they expected someone else to anticipate what they wanted. Interestingly, this problem has not arisen during interactions within the group. What seemed to help was that group members could see what might be done in someone else's situation, and then gradually applied those observations to themselves.

A couple of people had spoken to Anne, and reported she was in good spirits, even in the face of bad medical news. Thereafter in each session someone would update the group on her condition. She was ultimately unable to rejoin the group.

Session 11:

Attending: Betty, Walter, Harriet, James, Ginny, Steve

The majority of the session was spent on Betty's concerns in relation to her husband. She was really struggling with the issues of what is OK for her to request, to want, to feel resentment about. Her particular concern was whether she could ask her husband to accompany her to a doctor's appointment. She was worried about the test, did not want to impose on him, and was angry she could not have him there. Steve spent time exploring Betty's thoughts about how much she needs, deserves, could risk, could show to be vulnerable. After reviewing past interactions with her husband, she decided he had been there for her in critical situations, and that she really did not need him for the upcoming test. James added his thoughts about vunerability: he worries about being too vulnerable. James asked a good question at the session's end: "When is it good or OK or useful to be aggressive?" We should try to get back to that question. Walter seems to be feeling concerned about his decision to place his wife. He was tearful and shared with the group his "second thoughts." Walter has an interview at the board and care home next week.

DRAFT

Session 12:

Attending: James, Walter, Betty, Harriet, Ginny, & Steve

Before the meeting James took me aside and said he was disturbed, having just visited one of his few remaining friends in St. John's Hospital. His friend is facing surgery, and James is clearly concerned. He did not bring this up in the group (nor did Steve get to it), mainly since others took up the time. When he finally had a chance to speak at the end, there was little time left, and he talked about another issue.

Betty began, talking about the eye test she had been worried about the week before. It turned out to be fairly simple, taking only 20 minutes, and causing no distress. Her husband asked her this morning if she wanted him to come along with her. She decided she could do it on her own, and declined his offer, but did not feel resentment afterward. She had also checked with the doctor ahead of time to find out about the test, and decided that while she wanted the moral support, it was not a situation where she wanted to ask for Arnold's help.

DRAFT

In terms of her other concern, he had failed to call her one night, when he was late, but it was only 15 minutes. The next day she reminded him to call if he was going to be late. She said she is not as angry with him. She spoke more favorably about her friends. She said since Harriet talked about her problems with friends, it has been easier for Betty to accept what is good from her friends. She gave as an example going to a baby shower with some old friends who had hurt her feelings by not calling. Instead of thinking that they had not called her, last week she started calling again. herself talking with them, and

took what was good in the friendship.

Steve used that as a cue to ask Harriet about how her friendships were. She started by saying that at least Betty is married, and that some situations are worse. She was clearly having trouble getting out what she wanted to say. Finally, she said that her session of psychotherapy was troubling to her (she saw a therapist for individual counseling before the group meeting). and she was still upset, and preferred not talking about it. Steve said that was OK.

At that point Steve turned to Walter to find out about his visit to the Board and Care. The vacancy did not materialize so he was "back to square one." His wife is still manageable, but he would like to find a similar place for her. Through some discussion with the group, he cam up with what was so troubling to him is being unable to help her. Steve suggested he spend the week thinking how to make things easier on himself while he still has her, and he replied that his problem was all internal---attitude. Harriet commented on how much he had done for her and Steve said that he had really done a terrific job, and perhaps was too hard on himself. He did identify one issue that bothered him: that in the evening she will sometimes get upset with him when he does not pay attention to her, and will sulk or say she wants to go home. Steve said she is not angry at him, although it comes out that way but she is expressing how bad she feels about her condition. he seemed to understand that.

DRAFT

It was clearly difficult for him to talk at points, and finally said he wanted to hear from James. James said his problem was small in comparison to everyone else's. It involved the woman who got mad at him on New Year's Eve because he said he was too sick to go out. For awhile she was avoiding him, but

last week she started calling again. She would like to become involved with him, but he wants her just as a friend. His concern is that he feels he is hurting her by not giving more. The group tried to help, but there was not much time. It was pointed out that this issue was similar to many of the other interpersonal situations the group had raised.

The group ended early, as several people had to leave. At the end with just Betty and Harriet there, Steve thanked Harriet for being so helpful during the group. Whereas she and Walter usually clash, today he heard her out, and she was gentler with him. Betty said to her that she hoped her problems would get resolved, and gave her a hug.

DRAFT

Session 13:

No notes were taken in this session. Afterwards, Ginny and Steve talked about doing an exercise in the next session called "Positive Affirmations," as a way of making the positive feelings the group members expressed toward each other even stronger.

DRAFT

Session 14:

Attending: James, Walter, Betty, Harriet, Steve, & Ginny

Ginny had planned to spend the whole group doing positive affirmations, but since Walter had placed his wife in a Board and Care yesterday, the leaders decided to start the group pending some time talking about that. Walter said it had gone very well. She liked the place, and he was able to leave. One thing that bothered him was that a few days before she told another resident at their apartment that she was in a bad way, and that it was her fault. Walter wondered how she could have awareness of her situation and we talked again about the fact that her condition can fluctuate. He implied that if she had some awareness, he could not justify placing her.

DRAFT

He also was concerned about an episode of momentary blindness in one eye which occurred on Tuesday (the day before placing her). He went to see an opthalmologist who said it was caused by a piece of plaque breaking off from the carotid artery. He was very concerned about having a major stroke, but did not want to go to his doctor for an exam.

He then asked if Ginny would give her opinion of two versions of an advertisement he had prepared in which he offered to share his apartment in exchange for rent. One version advertised for a man, the other for a woman. The group was supportive, and encouraged him to place both ads. He said it was a big step for him and he needed support in doing it. All his life he had been independent. He said that it was nice for once to be able to be honest, serious, and still have the support from the group.

Following that, Ginny introduced the Affirmations exercise, explaining that we carry around negative statements about ourselves, and that these can be turned around in a more positive way. She gave the example of feeling she is not smart enough, and the group at first said that was silly to feel that way (not rational, they said) because she was smart. She made the point that her thoughts were not rational, but they affect her all the same. They then helped generate an alternative for her. ("I, Ginny, am smart enough for what I want to do.")

Once she had an alternative, she asked someone to identify a negative thought. James volunteered and said he was disturbed at how prejudiced he has become. Harriet suggested viewing persons as individuals, rather than as part of a group. James, however, said he had trouble doing that because the people he comes in contact with in his neighborhood or on the bus are impossible for himto deal with. Harriet continued to encourage James to separate the individual from the group, but that did not work. The group worked with him, trying rationalizations (it's just lower class people he's meeting, they're not all like that), but none of that worked. Finally, Ginny suggested the statement: "I, James, an concerned about being prejudiced." Both he and the group liked this statement. He tied that into his experiences in his neighborhood and on the bus.

DRAFT

After James, Harriet offered a problem: that she is feeling hopeless about ever attracting a man. She tied this in with her vision, saying she felt her poor vision limited her from driving to activities whee shemight meet someone, and that men treat her differently now that she cannot see well. As with James,

the group began by disputing her:

Harriet: I'd like a man who is affectionate and gives me loads of attention. But I not know where they are.

Betty: You seem to be ruling it out beore yove even tried it. You've tried it and had some bad experiences, but it doesn't mean you have to give it up. You're closing off your options. It just It just takes time in a limited environment. Sometimes if you worry about the pressure of time it shuts off your options.

Harriet: I'm pretty isolated.

Betty: But you go about.

Harriet: I go to my church meetings. More recently, I have the feeling that men begin to approach me, and when they get near me, they make a sharp right turn. They say, "Oh, that's Harriet who can't see."

At that point, Ginny tried to reframe the problem in a positive way.

Ginny: One affirmation could be: Harriet is an attractive person, including her vision problem.

DRAFT

Walter: She has to open more channels or else nothing is going to happen. What about jogging. Maybe you could meet someone while jogging.

Ginny: She has to believe that there's a positive thought.

Walter: I think they go hand in hand (lines of communication and positive thiought).

Betty: Here's a suggestion. I, Harriet, who am a sensitive, loving person, would like to meet a sensitive, loving man, and can do it.

Harriet: I don't think I can do it. I don't know where he is.

James: You need a certain amount of patience with a hope of expectation that this will materialize...I think you're impatient now.

Ginny: We're working on self advertising, becoming your own promotional person. Afirmation should not contain emphasis on the other person so much as it should contain affirmation of yourself.

Walter: What about: "I like me, and I'm sure others do too." With

that comes the exposure, and then comes the personal qualities.

Ginny: Or, "I, Harriet, know that men are waiting out there for me to reach out to them."

Harriet: It hits me as false.

Ginny: Here's an affirmation. It's OK to want an affectionate man.

Harriet: OK, I like that.

Betty: I have the same concerns you do, Harriet. Very often I feel my husband is unaffectionate and unloving, unsympathetic. Just because I have him doesn't mean that all my problems are solved. We have a problem in our relationship...the affection...so I'm appreciative of how upfront and honest you were. It took alotof strength to do that infront of the group.

Walter: This entire proceeding has allowed usall to open up to a degree that we really did not think was possible.

James: That expresses a great deal of confidence in each other. Among each other.

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This example shows how well the group was working together. Everyone seemed moved by the session, and there was a feeling of closeness at the end. Because time had run out before completing the affirmation exercise, it was decided to continue the next week.

There had also been discussion earlier in the group about having only 1 more session. No strong reactions to terminating were apparent.

Session 15:

Attending: Walter, James, Harriet, Betty, Steve, Ginny

The affirmations exercise started with Walter, but Walter was concerned about his wife, and talked about how he felt his emotions were controlling him, rather than the other way around.

Walter: For most of my life I've messed up the things that I've tried to do. How synonymous are brain and mind?

Steve: The brain is a physical entity and the mind is a process of the brain.

Walter: How do I account for my over reaction...how do I handle it without the irrational emotional response?

Steve: At the time of a major change it is natural. you took care of all that needed to be done, and after you put your wife in the home and care, you haven't felt as good as before.

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Walter: My blood pressure sky rocketed. What is the reason for going on? Who needs you? I think we all need to be needed.

Steve: This is a big change and it will take time to adjust. Time to get used to her not being around. Time to find out how to give meaning to your life.

Walter: 35 years ago, I would say to my wife, " you're good to come home to." 35 years later I was still saying that...I miss it.

Betty: Those good years to meant that, but she changed, and it couldn't be helped. It may have been better for you to have that pass.

Walter: I feel a little incomplete. I used to take her along on business when I went out of town.

Steve: Let's see if we can turn what Walter said into an affirmation. How many people have actually had that special relationship

Betty: In this case, it's not that you messed up, but it's something that happened to her.

Walter: That statement really wasn't pertaining. I did retire with the thought in mind that perhaps if I were with her everyday, her memory loss would get better, so I retired early. I wasted a lot of money in pursuit of that, and I neglected to get rich.

Betty: That's not screwing up.

Ginny: What about this as an affirmation: I shouldn't let my feelings dominate me.

Walter: We all have feelings, but who's driving this rig anyway. Yes, that I can live with. Who's in charge here.

Both the group and Walter liked his restatement, and there was further discussion.

Harriet: How do you apportion your time off...Most of the time you're laughing, joking, what is the portion of time that you're "facing yourself as you are."

Walter: The mask is always in place.

Harriet: What you're saying is that the mask is really in place. That's the game we play. I know I do it. I could be terribly depressed today, and after talking about it to people I feel I can talk to about it, the next day I'm completely in control of myself and quite happy.

Walter: I am in control of myself, but I find it necessary to project my interests outward...I volunteer, etc...I'm running away from myself.

Steve: Some of it isn't running. You have to reach out.

Harriet: It's normal to feel the death of someone, to mourn someone,...

Steve: It's normal to get some of the feelings out of control some of the time. The mask is adaptive. If you know it's normal to have them, and it's time to move away from them, then you've got the ability to do so. The first part is: it's normal to let feelings get away from you sometimes,

Betty: How about "give myself permission to be emotional at this crisis time?"

Walter: Despite the fact that you have these almost impossible standards for yourself to reach sometimes, and this is one of those times.

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Steve: Giving yourself permission to stay in that place. You'll keep doing the things that interest you.

Betty: It takes time...I give myself permission for this period of time, which is difficult.

Walter: Everything inside rebells against, although I appreciate what you're doing.

Ginny: Here are the things I wrote down:
1. I give myself permission to be emotional right now
2. I accept my style for handling my feelings
3. I like the way I'm learning to share my feelings

Walter: I have difficulty telling myself that I accept what I'm trying to reject...isn't it hypocritical?

Ginny: Well, the affirmation has to go against the pattern...if you feel backlash, then it will be useful.

Walter: Well, I've shared my feelings [illegible] I don't know if I like that.

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Harriet: I felt terrible when I left last time, because I had shared my feelings and exposed a weakness in myself.

Steve: What Ginny had tried to say is that everyone has a weakness, and they are often pointing out your strengths. Sensitivities are strengths. Walter, if you weren't feeling right now, we'd all be surprised. Harriet, if you were perfect, we'd really be surprised.

Harriet: I realize that, and one of my strengths is that I'm here.

Steve: It's not the weakness that makes you a weak person, it's the strength to know what to do with it. You had said, for example, that you were feeling depressed and talked to a friend and felt better.

Walter: I'm not sure if it's the feeling that bothers me. It's more of letting the feeling show that does.

Harriet: That's very much what I felt last week in sharing my feelings.

Ginny: I admire you because you share your feelings.

Steve: There are times to show them and times not to. There are different rules in different places. One of the things the group has done is given you a place where you shared

feelings that you might not somewhere else. It's good to do with people you care about.

Ginny: I have another affirmation. How about this? I, Walter, like my authenticity and also the fact that I can share.

Walter: I like me as I am because anything else is counterproductive

There was laughter and then a lot of positive statements about this statement. Walter seemed pleased with this affirmation, and the group's response. Athough they had not dealt with her case, Betty expressed feelings that she had benefitted, and did not need to do an affirmation of her own in that she had "worked with everybody else and learned from their experience." The group, however, insisted she try. Her concerns were about feeling unproductive, and the group finally generated an affirmation which helped her.

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There was then a discussion of how much the group had meant to them. They wanted to have other groups like this one, which were closed and time-limited. Finally, there was a discussion of ending the group, with everyone saying he/she would miss it.

Outcome:

In retrospect, probably the biggest gains were in the participants' social relationships. Changes came from suggestions made by other group members, and, at critical points, by observing someone else in the group coping with a similar problem as one's own. They would give someone else advice, and then realize that advice pertained to them, as well. Teaching them to use the cognitive approach for dealing with depression was less successful. While this approach was useful in sessions, it did not appear that individuals could use it on their own, as yet. Perhaps 15 sessions were not enough, or the method only had limited usefulness for them. There also could have been more emphasis on training them to use the method.

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Follow-ups several months later were made. Walter continued to have the most ups and downs, mainly around his wife's situation. He would become despondent at times, especially when it became apparent his wife had to be moved to a nursing home. The other three participants all increased their volunteer activities, and reported enjoying their involvement. Anne's hospitalization lasted a few months, and she had only just gotten out at the time of the follow-up.

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Appendix E

Evaluation Measures

Foreword

The attached paper and pencil measures are part of an evaluation of your graduate training program in clinical psychology. Increasingly, evaluation will be required by training grants, and this evaluation is part of an Administration on Aging training grant in clinical psychology and gerontology that we currently enjoy. The results may be useful in helping us secure further training money. Moreover, there is a paucity of sound research on the effects of graduate training in clinical psychology and we're in the unique position of being able to provide some useful data.

The evaluation includes these paper and pencil questionnaires, demographics, a description of your prior clinical experience, and videotaping of your interviewing skills. A portion of these procedures will be repeated again at the beginning of next semester. We are not interested in evaluating you as individuals, and the data will not be analyzed on an individual basis. We are interested in gaining a sense for, on the average, what students at your level of training are like.

Two minutes into this first questionnaire, many of the attributes that we are attempting to assess will undoubtedly become evident to you. You may even recognize some of the specific instruments. Many of you also know a lot about response bias, social desirability, lie scales, and the like. In short, you are simply too sophisticated to be outfoxed. So, rather than trying to disguise our purposes, we are appealing to the scientific curiosity embedded in your soul (or at least in your role), and we are asking you to make an agreement with us. The agreement is that you fill out the scales as candidly as you can and that you not discuss the specifics of any evaluation procedure (questionnaires, interviews, etc.) with one another. (Because the paper and pencil measures are standardized instruments, please bear with sexist and other archaic wording.) The quality and usefulness of the pooled results will depend on the honesty of each individual's responses. Moreover, because different classes will be involved in different steps of the evaluation at later points in time, cross-talk could skew the data in unpredictable and uninterpretable directions.

In turn, then, we agree to provide the results to you at the conclusion of the study, and we will answer any other questions you may have about this evaluation. You may find the results as well as the participation itself both interesting and thought-provoking.

Your response to this and other steps in the evaluation will be handled with the following discretion: We are asking you to assign yourself a three-digit code number, which is how you will identify yourself on all your evaluation material. Members of the evaluation team (Gatz, Pearse) will have occasion to associate a number with a name or a face, but we are the only persons who will have access to that information. Please put your name on one side of the detachable file card and the number of your choice (choose one that's memorable) on the other side. If there are duplicates, we'll let you know. After the final data have been collected, the file cards will be destroyed.

After you have completed the paper and pencil measures, the immediate next step is the demographic and experience questionnaire. You may take it home with you, but please fill it out by Sunday night at the latest (a rough control for time of measurement). Make sure your code number is on it. You may return it in the envelope either to the "ballot box" in SGM 518 or to Margy's mail box, or you may drop it off when you come to do your interview. In this step, as in all others, data will be logged in by code number. The only reason we would need to cross-check name and code would be if we don't receive the questionnaire and have to find out why (or if you forget your memorable number and ask us to look it up).

Thank you for your help!

DATE_____ CODE NUMBER_____

INSTRUCTIONS: (Please read them, regardless of your level of sophistication!)

Listed below are a number of statements. Each represents a commonly held opinion and there are no right or wrong answers. You will probably disagree with some items and agree with others. We are interested in the extent to which you agree or disagree with such matters of opinion.

Read each statement carefully. Then indicate the extent to which you agree or disagree by circling the number in front of each statement. The numbers and their meaning are indicated below:

If you agree strongly, circle +3
If you agree somewhat, circle +2
If you agree slightly, circle +1

If you disagree slightly, circle -1
If you disagree somewhat, circle -2
If you disagree strongly, circle -3

First impressions are usually best in such matters. Read each statement, decide if you agree or disagree and the strength of your opinion, and then circle the appropriate number in front of the statement. Give your opinion on every statement.

If you find that the numbers to be used in answering do not adequately indicate your own opinion, use the one which is closest to the way you feel.

		Agree			Disagree		
1.	It is safest to assume that all people have a vicious streak and it will come out when they are given a chance.	+3	+2	+1	-1	-2	-3
2.	The biggest difference between most criminals and other people is that the criminals are stupid enough to get caught.	+3	+2	+1	-1	-2	-3
3.	Teachers or supervisors who hand out vague assignments give a chance for one to show initiative and originality.	+3	+2	+1	-1	-2	-3
4.	It must be quite a shock to look in the mirror and find that you are showing signs of aging.	+3	+2	+1	-1	-2	-3
5.	Residences for retired persons should always work out their programs and routines with the old persons concerned.	+3	+2	+1	-1	-2	-3
6.	Most men are brave.	+3	+2	+1	-1	-2	-3
7.	It is possible to be good in all respects	+3	+2	+1	-1	-2	-3
8.	I cannot help feeling depressed at the thought of getting old.	+3	+2	+1	-1	-2	-3
9.	Honesty is the best policy in all cases.	+3	+2	+1	-1	-2	-3
10.	Anyone could keep young if he only tried.	+3	+2	+1	-1	-2	-3
11.	I view death as a release from earthly suffering.	+3	+2	+1	-1	-2	-3
12.	It would probably be better if most old people lived in residential units that also housed younger people.	+3	+2	+1	-1	-2	-3
13.	Most old people make excessive demands for love and attention.	+3	+2	+1	-1	-2	-3
14.	Most old people tend to let their homes become shabby and unattractive.	+3	+2	+1	-1	-2	-3

		Agree			Disagree		
15.	Not knowing what it feels like to be dead does not bother me.	+3	+2	+1	-1	-2	-3
16.	When you are no longer a contributing member of society by functioning in such roles as worker, parent, and so on, you can't really feel that you have any value as a person.	+3	+2	+1	-1	-2	-3
17.	Barnum was wrong when he said that there's a sucker born every minute.	+3	+2	+1	-1	-2	-3
18.	No matter what the community can do, it is up to the children to see that their aging parents have every comfort.	+3	+2	+1	-1	-2	-3
19.	On the whole, people's chances in life are getting worse and not better.	+3	+2	+1	-1	-2	-3
20.	I often feel that many things our parents stood for are just going to ruin before our very eyes.	+3	+2	+1	-1	-2	-3
21.	Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.	+3	+2	+1	-1	-2	-3
22.	I like parties where I know most of the people more than ones where all or most of the people are complete strangers.	+3	+2	+1	-1	-2	-3
23.	I would not mind dying young.	+3	+2	+1	-1	-2	-3
24.	I am not disturbed by death being the end of life as I know it.	+3	+2	+1	-1	-2	-3
25.	Relatives who were close to the parents in former years rightly expect the children to care about their well being if they live a very long life.	+3	+2	+1	-1	-2	-3
26.	Many of our most important decisions are based upon insufficient information.	+3	+2	+1	-1	-2	-3
27.	Most old people need no more love and reassurance than anybody else.	+3	+2	+1	-1	-2	-3
28.	You're further ahead if you always assume that everybody is out for Number One.	+3	+2	+1	-1	-2	-3
29.	The sooner we all acquire similar values and ideals the better.	+3	+2	+1	-1	-2	-3
30.	A good teacher is one who makes you wonder about your way of looking at things.	+3	+2	+1	-1	-2	-3
31.	I am disturbed by the physical degeneration involved in a slow death.	+3	+2	+1	-1	-2	-3
32.	People who fit their lives to a schedule probably miss most of the joy of living.	+3	+2	+1	-1	-2	-3
33.	In order to maintain a nice residential neighborhood, it would be best if too many old people did not live in it.	+3	+2	+1	-1	-2	-3
34.	Everything changes so quickly these days that I often have trouble deciding which are the right rules to follow.	+3	+2	+1	-1	-2	-3
35.	Old people have too little power in business and politics.	+3	+2	+1	-1	-2	-3
36.	There is no point in talking about personal matters with people who are much older or much younger than yourself.	+3	+2	+1	-1	-2	-3

		Agree			Disagree		
37.	When you ask someone to do something for you, it is best to give the real reasons for wanting it rather than giving reasons which carry more weight.	+3	+2	+1	-1	-2	-3
38.	People in high offices aren't really interested in the troubles of the average person.	+3	+2	+1	-1	-2	-3
39.	The total isolation of death frightens me.	+3	+2	+1	-1	-2	-3
40.	What is lacking in the world today is the old kind of friendship that lasted for a lifetime.	+3	+2	+1	-1	-2	-3
41.	A good job is one where what is to be done and how it is to be done are always clear.	+3	+2	+1	-1	-2	-3
42.	Most old people are really no different from anybody else; they're as easy to understand as younger people.	+3	+2	+1	-1	-2	-3
43.	It would probably be better if most old people lived in residential units with people their own age.	+3	+2	+1	-1	-2	-3
44.	Anyone who completely trusts anyone else is asking for trouble.	+3	+2	+1	-1	-2	-3
45.	When you retire you realize that the best years of your life are yet to come.	+3	+2	+1	-1	-2	-3
46.	It is wise to flatter important people.	+3	+2	+1	-1	-2	-3
47.	Never tell anyone the real reason you did something unless it is useful to do so.	+3	+2	+1	-1	-2	-3
48.	You can't expect other people to take care of you when you no longer can take care of yourself.	+3	+2	+1	-1	-2	-3
49.	Most old people are irritable, grouchy and unpleasant.	+3	+2	+1	-1	-2	-3
50.	The pain involved in dying frightens me.	+3	+2	+1	-1	-2	-3
51.	An expert who doesn't come up with a definite answer probably doesn't know too much.	+3	+2	+1	-1	-2	-3
52.	Most old people can generally be counted on to maintain a clean, attractive home.	+3	+2	+1	-1	-2	-3
53.	Old people have too much power in business and politics.	+3	+2	+1	-1	-2	-3
54.	There is something different about most old people; it's hard to figure out what makes them tick.	+3	+2	+1	-1	-2	-3
55.	The trouble with the world today is that most people really don't believe in anything.	+3	+2	+1	-1	-2	-3
56.	There are a few exceptions, but in general most old people are pretty much alike.	+3	+2	+1	-1	-2	-3
57.	There is no excuse for lying to someone else.	+3	+2	+1	-1	-2	-3
58.	It is more fun to tackle a complicated problem than to solve a simple one.	+3	+2	+1	-1	-2	-3
59.	With everything in such a state of disorder, it's hard for a person to know where he stands from one day to the next.	+3	+2	+1	-1	-2	-3
60.	A person's worth does not depend on how good a citizen, parent, or worker he or she is, but simply that he or she is a human being.	+3	+2	+1	-1	-2	-3
61.	Most old people would prefer to quit work as soon as pensions or their children can support them.	+3	+2	+1	-1	-2	-3

		Agree			Disagree		
62.	I would avoid death at all costs.	+3	+2	+1	-1	-2	-3
63.	Unless I feel that I have accomplished or done something that other people value, I feel quite worthless.	+3	+2	+1	-1	-2	-3
64.	Old age is O.K. for those who are financially independent.	+3	+2	+1	-1	-2	-3
65.	When there is a sizable number of old people living in a residential neighborhood, you can count on its being nice.	+3	+2	+1	-1	-2	-3
66.	Most old people are capable of new adjustments when the situation demands it.	+3	+2	+1	-1	-2	-3
67.	Most old people spend too much time prying into the affairs of others and in giving unsought advice.	+3	+2	+1	-1	-2	-3
68.	The feeling that I might be missing out on so much after I die bothers me.	+3	+2	+1	-1	-2	-3
69.	It is foolish to claim that wisdom comes with old age.	+3	+2	+1	-1	-2	-3
70.	It is hard to get ahead without cutting corners here and there.	+3	+2	+1	-1	-2	-3
71.	It is evident that most old people are very different from one another.	+3	+2	+1	-1	-2	-3
72.	The intellectual degeneration of old age disturbs me.	+3	+2	+1	-1	-2	-3
73.	One shouldn't try to involve elderly people in things; all they really want is some peace and comfort.	+3	+2	+1	-1	-2	-3
74.	Most people are basically good and kind.	+3	+2	+1	-1	-2	-3
75.	If old people expect to be liked, their first step should be to try to get rid of their irritating faults.	+3	+2	+1	-1	-2	-3
76.	It is rather sad to be still alive after all your friends are gone.	+3	+2	+1	-1	-2	-3
77.	One should take action only when sure it is morally right.	+3	+2	+1	-1	-2	-3
78.	I am disturbed by the thought that my abilities will be limited while I lay dying.	+3	+2	+1	-1	-2	-3
79.	Most old people are constantly complaining about the behavior of the younger generation.	+3	+2	+1	-1	-2	-3
80.	What we are used to is always preferable to what is unfamiliar.	+3	+2	+1	-1	-2	-3
81.	When you think about it, old people have the same faults as anybody else.	+3	+2	+1	-1	-2	-3
82.	There is really no such thing as a problem that can't be solved.	+3	+2	+1	-1	-2	-3
83.	All in all, it is better to be humble and honest than to be important and dishonest.	+3	+2	+1	-1	-2	-3
84.	Most times I feel relaxed in the company of elderly people.	+3	+2	+1	-1	-2	-3
85.	A person isn't worth much when he or she is no longer able to carry on as a productive member of the community.	+3	+2	+1	-1	-2	-3
86.	You'll never get old if you don't let yourself go.	+3	+2	+1	-1	-2	-3
87.	You're likely to get bogged down if you let elderly people help you with your projects.	+3	+2	+1	-1	-2	-3
88.	I am disturbed by the shortness of life.	+3	+2	+1	-1	-2	-3

		Agree			Disagree		
89.	A person who leads an even, regular life in which few surprises or unexpected happenings arise, really has a lot to be grateful for.	+3	+2	+1	-1	-2	-3
90.	Most old people respect others' privacy and give advice only when asked.	+3	+2	+1	-1	-2	-3
91.	The future is so uncertain that there is little point in thinking or planning ahead.	+3	+2	+1	-1	-2	-3
92.	In the long run it is possible to get more done by tackling small, simple problems rather than large and complicated ones.	+3	+2	+1	-1	-2	-3
93.	Often the most interesting and stimulating people are those who don't mind being different and original.	+3	+2	+1	-1	-2	-3
94.	Retired people are happiest in the company of people their own age.	+3	+2	+1	-1	-2	-3
95.	All community organizations should have some older persons on their boards.	+3	+2	+1	-1	-2	-3
96.	People who spend all they make cannot expect much when they are no longer earning a living.	+3	+2	+1	-1	-2	-3
97.	The idea of never thinking or experiencing again after I die does not make me anxious.	+3	+2	+1	-1	-2	-3
98.	Most men forget more easily the death of their father than the loss of their property.	+3	+2	+1	-1	-2	-3
99.	The best way to handle people is to tell them what they want to hear.	+3	+2	+1	-1	-2	-3
100.	Most people who get ahead in the world lead clean, moral lives.	+3	+2	+1	-1	-2	-3
101.	You can't expect old people to exert themselves.	+3	+2	+1	-1	-2	-3
102.	No one who is retired and over 70 should be allowed to drive a car.	+3	+2	+1	-1	-2	-3
103.	People suffering from incurable diseases should have the choice of being put painlessly to death.	+3	+2	+1	-1	-2	-3
104.	One of the more interesting qualities of old people is when they talk about their past experiences.	+3	+2	+1	-1	-2	-3
105.	Most old people are very relaxing to be with.	+3	+2	+1	-1	-2	-3
106.	Most old people are cheerful, agreeable and good-humored.	+3	+2	+1	-1	-2	-3
107.	People who insist upon a yes or no answer just don't know how complicated things really are.	+3	+2	+1	-1	-2	-3
108.	The best neighborhoods are those where young families intermingle with retired people.	+3	+2	+1	-1	-2	-3
109.	If I had a fatal disease, I would like to be told.	+3	+2	+1	-1	-2	-3
110.	Most old people bore others by their insistence on talking about the "good old days".	+3	+2	+1	-1	-2	-3
111.	Dying might be an interesting experience.	+3	+2	+1	-1	-2	-3
112.	Most old people should be more concerned about their personal appearance; they're too untidy.	+3	+2	+1	-1	-2	-3
113.	Generally speaking, men won't work hard unless they're forced to do so.	+3	+2	+1	-1	-2	-3

		Agree			Disagree		
114.	You can't cope with things the way you used to if you live to be a ripe old age.	+3	+2	+1	-1	-2	-3
115.	By and large, young people don't care about anyone but themselves.	+3	+2	+1	-1	-2	-3
116.	I would like to live in a foreign country for a while.	+3	+2	+1	-1	-2	-3
117.	Old age pensioners have a right to be taken care of in a dignified way even if younger people must contribute their taxes to make this possible.	+3	+2	+1	-1	-2	-3
118.	People grow wiser with the coming of old age.	+3	+2	+1	-1	-2	-3
119.	With everything so uncertain these days, it almost seems as though anything could happen.	+3	+2	+1	-1	-2	-3
120.	Most old people make one feel ill at ease.	+3	+2	+1	-1	-2	-3
121.	One seldom hears old people complaining about the behavior of the younger generation.	+3	+2	+1	-1	-2	-3
122.	Most old people get set in their ways and are unable to change.	+3	+2	+1	-1	-2	-3
123.	Most old people seem to be quite clean and neat in their personal appearance.	+3	+2	+1	-1	-2	-3
124.	The older people get, the more they think only of themselves.	+3	+2	+1	-1	-2	-3

The statements listed below are a quick overview of a lot of material about aging. Part of it is factual and part is based on stereotypes. The purpose is to get an initial assessment of the information you know.

For each of the following statements, please circle true or false. Do not skip any questions.

125.	Old age is a time of relative peace and tranquility.	T	F
126.	Emotional disturbance in younger years is highly correlated with emotional disturbance in later life.	T	F
127.	The incidence of serious mental illness increases with age.	T	F
128.	Symptoms of organic brain impairment are easily distinguishable from those of functional impairment.	T	F
129.	Poor nutrition is a problem which plagues older people.	T	F
130.	Depression occurs more frequently among older people than among the young.	T	F
131.	At least three-fourths of the elderly express a fear of death.	T	F
132.	Older widows adjust to their loss better than younger widows.	T	F
133.	Elderly persons complain of sleep disturbances more often than do younger persons.	T	F
134.	One-fourth of the suicides in the U.S. are committed by persons 65 years of age and older.	T	F
135.	Drug abuse is not a serious problem of the elderly.	T	F
136.	At least one-fourth of the aged residing in nursing homes suffer from psychiatric illness.	T	F
137.	Most older adults have little contact with their children.	T	F

138. Approximately 15% of the older population are in need of immediate mental health services. T F

139. Psychotherapy is ineffective with older patients. T F

140. Most mental health problems of older adults cannot be prevented. T F

141. The majority of old people (past age 65) are senile (i.e., deficient in memory, disoriented or demented). T F

142. All five senses tend to decline in old age. T F

143. Most old people have no interest in, or capacity for, sexual relations. T F

144. Lung capacity tends to decline in old age. T F

145. The majority of old people feel miserable most of the time. T F

146. Physical strength tends to decline in old age. T F

147. At least one-tenth of the aged are living in long-stay institutions (i.e., nursing homes, mental hospitals, homes for the aged, etc.). T F

148. Aged drivers have fewer accidents per person than drivers under age 65. T F

149. Most older workers cannot work as effectively as younger workers. T F

150. About 80% of the aged are healthy enough to carry out their normal activities. T F

151. Most older people are set in their ways and unable to change. T F

152. Old people usually take longer to learn something new. T F

153. It is almost impossible for most old people to learn new things. T F

154. The reaction time of most old people tends to be slower than reaction time of younger people. T F

155. In general, most old people are pretty much alike. T F

156. The majority of older people are seldom bored. T F

157. The majority of old people are socially isolated and lonely. T F

158. Older workers have fewer accidents than younger workers. T F

159. Over 15% of the U.S. population are now age 65 or over. T F

160. Most medical practitioners tend to give lower priority to the aged. T F

161. The majority of older people have incomes below the poverty level (as defined by the Federal Government). T F

162. The majority of old people are working or would like to have some kind of work to do (including housework and volunteer work). T F

163. Older people tend to become more religious as they age. T F

164. The majority of old people are seldom irritated or angry. T F

165. The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be about the same as now. T F

DATE_____ CODE NUMBER_____

The following questions are related to your personal background and training experience. The information will be used for statistical analysis only and will not be used for identification of anyone participating in the study.

I. Your age_____/Sex_____/Number of children_____

Marital: Never married_____/Married_____/Separated_____/Divorced_____/Widowed_____

In what kind of program are you currently enrolled? Masters_____/Ph.D._____

What year of your program are you in now?_____

What is the highest degree you have obtained so far?

BA_____/BS_____/Masters_____/Specialty certificate_____/Ph.D._____

Do you intend to pursue further degrees after you finish your current program? Yes____/No____

Please indicate to the best of your ability the professional plans you have at this point in your education (check wherever applicable):

Research_____/Teaching_____/Direct service_____/Administration_____

Indicate which age groups you are interested in:

Children_____/Adolescents_____/College students_____/Adults_____/Older adults_____

Do you currently have an area of specialization? Yes____/No____/ If so, what is it?

Clinical-aging_____/Child clinical_____/Other (e.g. health psychology, psychology and law, industrial psychology)_____

Listed below are some reasons people frequently cite when describing their career paths. Try to reflect back to the time when you decided to pursue your current interest, and rate <u>each</u> item according to how much it influenced your choice of specialty. NOTE: If you did not indicate having an area of specialization, please rate the items with respect to why you chose clinical psychology as a career. Use a five-point scale where 1 = not at all and 5 = a very great deal.

_____Had a particularly inspiring mentor

_____Had a relative or close friend with problems related to the area

_____Liked the people in the field

_____Had an important role model

_____Took an intriguing course in the area

_____Wanted to be of service, be helpful

_____Wanted to facilitate social change

_____Had a research position in the area

_____Was offered a stipend or traineeship

_____Had a direct service position in the area

_____Interacted well with the population served

_____Availability of jobs or career opportunities

_____The theories fit well with my way of thinking

_____It was something I didn't know about so I wanted to learn

_____It satisfied my desire for multidisciplinary study

Please elaborate on the items you rated highly, and list any other factors, individuals, or experiences that were particularly relevant at the time you made your decision. Feel free to be expansive here--continue on the back of the page if you like.

Reconsider these items in terms of the present--that is, what is important to you now. Have any of the factors changed their weightings? Please rate each item according to its current importance. Use the same five-point scale where 1 = not at all and 5 = a very great deal.

_____Had a particularly inspiring mentor

_____Had a relative or close friend with problems related to the area

_____Liked the people in the field

_____Had an important role model

_____Took an intriguing course in the area

_____Wanted to be of service, be helpful

_____Wanted to facilitate social change

_____Had a research position in the area

_____Was offered a stipend or traineeship

_____Had a direct service position in the area

_____Interacted well with the population served

_____Availability of jobs or career opportunities

_____The theories fit well with my way of thinking

_____It was something I didn't know about so I wanted to learn

_____It satisfied my desire for multidisciplinary study

Have any factors you added changed in importance, or have any new ones emerged? Please elaborate.

Did you enter your current program: Straight out of college_____/From a closely related field (specify)_____/From an entirely different profession (specify)_____/Other (specify)_____

Check the appropriate column to indicate how many undergraduate and graduate courses you have taken in the following categories. Count each course only once. If you feel it could fit in more than one category, choose the one that it fits best.

	Numbers of courses				
	0	1	2-3	4-5	6+
In aging	____	____	____	____	____
In lifespan development	____	____	____	____	____
With a significant component devoted to aging	____	____	____	____	____

Briefly indicate any volunteer, occupational or social experiences you may have had that involved a significant amount of contact with older adults (e.g. nurses aide, church, waiter or clerk, riding the bus). If possible, approximate the total amount of contact time you had for each experience.

Briefly describe your reaction (i.e. how you felt, emotions you experienced, attitudes which were established or re-evaluated).

II. The following section pertains to your clinical experience.

What is your theoretical orientation?_____

Check the appropriate column to designate the number of patients you have seen in therapy for each category:

	Numbers of patients						
	0	1-4	5-9	10-14	15-19	20-29	30+
Children	____	____	____	____	____	____	____
Adolescents	____	____	____	____	____	____	____
College students	____	____	____	____	____	____	____
Adults	____	____	____	____	____	____	____
Aged	____	____	____	____	____	____	____
Couples	____	____	____	____	____	____	____
Families	____	____	____	____	____	____	____

Check the number of <u>therapy</u> groups you have led or co-led in each category:

	Numbers of groups					
	0	1	2	3	4	5+
Children						
Adolescents						
College students						
Adults						
Aged						
Couples						
Families						

Check the appropriate column to designate the number of patients you have seen for testing (assessment batteries) using standard instruments such as the WAIS-R or Luria.

	Numbers of patients						
	0	1-4	5-9	10-14	15-19	20-29	30+
Children							
Adolescents							
College students							
Adults							
Aged							
Couples							
Families							

Check the appropriate column to designate the number of patients you have seen for intake interviews or mental status exams:

	Numbers of patients						
	0	1-4	5-9	10-14	15-19	20-29	30+
Children							
Adolescents							
College students							
Adults							
Aged							
Couples							
Families							

Check where you have had experience in indirect psychological services, indicating the age group(s) served (include such settings and organizations as police, schools, hospitals, nursing homes, etc.):

	Child	Adolescent	College	Adult	Aged
Consultation	____	____	____	____	____
Program evaluation	____	____	____	____	____
Mental health administration	____	____	____	____	____
Community outreach	____	____	____	____	____
Training	____	____	____	____	____
Supervision	____	____	____	____	____
Grant writing	____	____	____	____	____
Other:					
_____	____	____	____	____	____
_____	____	____	____	____	____

III. The following section is aimed at getting a sense of some of your formative relationships--both positive and negative, pleasant and unpleasant. Please list the years the following people were born and, if applicable, deceased. If giving their current age is easier, please do so, although an approximation of their birth year is preferable.

	Born	Deceased		Born	Deceased
Mother	_____	_____	Maternal grandmother	_____	_____
Father	_____	_____	Maternal grandfather	_____	_____
Sister	_____	_____	Paternal grandmother	_____	_____
Sister	_____	_____	Paternal grandfather	_____	_____
Brother	_____	_____			
Brother	_____	_____			

The tables on the following two pages should be used flexibly despite their somewhat formal appearance. Feel free to add to them, using marginal notes or footnotes to amplify your response--e.g., you may want to include step parents, brief but significant changes in your living environment, a sudden absence of an important person, or the circumstances surrounding a marked shift of valence of a relationship.

In the following table, please check in the appropriate columns to indicate approximately how close you lived to your parents and grandparents and how frequently you had contact with them (including letters and phone conversations) during childhood, adolescence, and adulthood (since high school). The final column addresses your impressions of your relationships. Please circle NA if the relationship was (is) inconsequential, and use the following scale for recording the valence of significant relationships:

Circle 1 if the quality of the relationship was almost all negative
Circle 2 if the quality of the relationship was more negative than positive
Circle 3 if the quality of the relationship was about an equal mix of negative and positive
Circle 4 if the quality of the relationship was more positive than negative
Circle 5 if the quality of the relationship was almost all positive

	Proximity					Frequency					Valence
	Lived with	Within 1 mile	Within 10 miles	Within 50 miles	Over 50 miles	Daily	Weekly or more	Monthly or more	Yearly or more	Less than yearly	
During childhood											
Mother	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Father	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Maternal grandmother	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Maternal grandfather	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Paternal grandmother	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Paternal grandfather	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
During adolescence											
Mother	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Father	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Maternal grandmother	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Maternal grandfather	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Paternal grandmother	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Paternal grandfather	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
During adulthood											
Mother	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Father	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Maternal grandmother	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Maternal grandfather	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Paternal grandmother	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5
Paternal grandfather	___	___	___	___	___	___	___	___	___	___	NA 1 2 3 4 5

Occasionally people have adults other than their parents or grandparents who have had long-term significance in their lives--neighbors, aunts, uncles, or foster parents, for example. If there were such people, please identify them in the left-hand column and give some indication of their age (their date of birth, their age now, or their age range during the period when they were most significant in your life). Then check in the appropriate columns to indicate approximately how close you lived to them and how frequently you had contact with them (including letters and phone conversations) during childhood, adolescence, and adulthood (since high school). Again, the final column addresses your impressions of the valence of the relationship. Circle NA for periods when the relationship was (is) inconsequential, and use the same scale as before for indicating the valence (from 1 = almost all negative to 5 = almost all positive).

Identity:_____ Age indicator:_____

	Proximity					Frequency					Valence
	Lived with	Within 1 mile	Within 10 miles	Within 50 miles	Over 50 miles	Daily	Weekly or more	Monthly or more	Yearly or more	Less than yearly	
During childhood											NA 1 2 3 4 5
During adolescence											NA 1 2 3 4 5
During adulthood											NA 1 2 3 4 5

Identity:_____ Age indicator:_____

	Proximity					Frequency					Valence
	Lived with	Within 1 mile	Within 10 miles	Within 50 miles	Over 50 miles	Daily	Weekly or more	Monthly or more	Yearly or more	Less than yearly	
During childhood											NA 1 2 3 4 5
During adolescence											NA 1 2 3 4 5
During adulthood											NA 1 2 3 4 5

Identity:_____ Age indicator:_____

	Proximity					Frequency					Valence
	Lived with	Within 1 mile	Within 10 miles	Within 50 miles	Over 50 miles	Daily	Weekly or more	Monthly or more	Yearly or more	Less than yearly	
During childhood											NA 1 2 3 4 5
During adolescence											NA 1 2 3 4 5
During adulthood											NA 1 2 3 4 5

We are interested in other adults who may have had brief but important formative influences in your life--relatives, neighbors, teachers, scout leaders, for example. Please identify and describe any such persons, providing information that parallels the information on the preceding tables.

1. Identity/role of person: _____
   Proximity and frequency of contact: _____
   Valence of relationship: 1 2 3 4 5
   Your age at the time of their greatest importance to you: _____
   Their approximate age at that same time: _____
2. Identity/role of person: _____
   Proximity and frequency of contact: _____
   Valence of relationship: 1 2 3 4 5
   Your age at the time of their greatest importance to you: _____
   Their approximate age at that same time: _____
3. Identity/role of person: _____
   Proximity and frequency of contact: _____
   Valence of relationship: 1 2 3 4 5
   Your age at the time of their greatest importance to you: _____
   Their approximate age at that same time: _____

Please rank order the people you have mentioned on this and the two preceding pages in terms of the importance of their influence on you being the person you are today (1 = most influential; ties are OK).

Mother		____
Father		____
Maternal grandmother		____
Maternal grandfather		____
Paternal grandmother		____
Paternal grandfather		____
Others you have mentioned (please specify):	_____	____
	_____	____
	_____	____
	_____	____
	_____	____
	_____	____

Have you had contact with these or other important adults during times when they were physically ill? Yes_____/No_____/ During hospitalization? Yes_____/No_____/ During other institutionalized care? Yes_____/No_____

Briefly describe your reaction (i.e., how you felt, emotions you experienced, attitudes which were established or re-evaluated):

In a word or two, how did you feel while completing this form?

Thanks very much for your help.

CODE # _____

SET A

INSTRUCTIONS:

Attached are two intake summaries adapted from real case material. Assume each is dated January 1983. Read each summary; then, based on the information given, answer the following five questions about each case. Use as much paper as you need, and write your code number on each piece. Start a new page for the second case, and put the client's name at the top of each write up. If some of what is being asked for is unfamiliar to you, just respond however you can. Although it might be possible for some of you to linger over this task for quite some time, we are asking you to allow about 20 minutes per case and definitely not to take over an hour altogether.

1. How would you formulate the problem (for example, what is your diagnostic impression? What has brought the individual into treatment now?)

2. Write up Goals for Treatment (that is, list the issues to be addressed in treatment and the type of change that you would hope to achieve)

3. Write up a Treatment Plan (that is, make recommendations, list the steps that you would take as the therapist, and describe your treatment approach)

4. What more would you want to know (what assessment questions are left unanswered?)

5. How do you view the prognosis.

Remember, please <u>do not discuss</u> these cases with your classmates.

(Gatz, Pearson & Zemansky, 1982)

Client: Peggy S.

1. Behavior during interview and physical description:

Although Peggy was neatly groomed and her clothing well-coordinated, her overall appearance was meek and mousy. She rarely made eye contact during the interview and she spoke in a tired monotone. She volunteered almost no information and answered questions with as few words as possible. Her facial expression was uniformly sad, even in response to positive feedback. She looks older than her 64 years.

2. Description of presenting problem:

Peggy came in for help getting over a depression. She claims to have been depressed since last year when she began to think of her upcoming retirement and the increasing amount of unfilled time that she would have on her hands. She slowly became more withdrawn and her social contacts dwindled. In June of last year Peggy went to four sessions with a psychiatrist who prescribed Ascendin. She feels the medication has made her less anxious, but she doesn't feel that she benefitted much psychologically from the visits.

Peggy feels she was able to cope very well despite her depression until she was attacked outside her Echo Park home this last December. Her garage door opener didn't function when she returned home one evening, and she was grabbed when she left her car to open the door manually. Her screams alerted a neighbor and scared off the attacker, who pushed her against her car as he fled. Although she was uninjured, she remains fearful of going outside. She remains at home alone and rarely sees others. Moreover, she has begun to neglect the care of her home. Recently there have been several occasions where she has forgotten where she has put things, such as her address book.

A further concern is financial. Peggy owns her own home and is considering selling it and moving to an apartment to release the equity. She has mixed feelings about carrying out this move.

3. Current situational determinants:

a. Attack last December--no bodily injury

b. Retired last August--40 years as accountant for Kaiser

4. Description of social network:

Peggy has two married sons in their thirties, each of whom has one child. She sees her sons and their families frequently when they travel from their homes in Thousand Oaks and Whittier to have Sunday brunch with her. She raised her two sons alone, following her husband's sudden death in 1949. She also has a 98-year-old mother who resides in a nursing home in Alhambra. She used to visit her regularly prior to being attacked, but found it very depressing. Her mother had lived with her for some time prior to being hospitalized in 1973, after which she was transferred to the nursing home. In recent years, the mother's mental and physical health have declined. Peggy's outside interests have always been limited due to family and work commitments. She has enjoyed attending garden club, which she did regularly until the group broke up recently.

(Gatz, Pearson & Zemansky, 1982)

5. Mental status screening:

Memory testing showed no impairment. Peggy scored 41 on the Beck Depression Inventory, asserting that she feels sad all the time, feels a failure, feels punished and guilty, blames herself, can't make decisions, and has little energy.

6. a. Sleep and appetite:

Peggy sleeps six hours per night, whereas she used to sleep a regular eight before her retirement. She sometimes has difficulty falling asleep and wakes up frequently in the middle of the night. She has a poor appetite and has lost 12 pounds in the past four months.

b. Brief medical history:

Overall good health. Has chronic post-nasal drip.

c. Current medications:

Ascendin, 150 mg at bedtime.

d. Suidical ideation:

Occasional thoughts, such as "I'd be better off gone". No plan.

e. Sensory loss:

Complains that vision is not as good as it should be. A recent eye exam revealed no problems with her eyeglass prescription.

7. History of prior behavioral problems/psychiatric treatment:

Peggy was depressed once before, in 1948, following the birth of her second son. She recovered by keeping busy attending to the new baby. In general, she has coped with past problems by keeping busy. The psychiatrist she saw in June 1982 functioned only to provide medication.

(Gatz, Pearson & Zemansky, 1982)
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Clients' Names: Sherman and Sally K.

1. Behavior during interview and physical description:

Sherman is a frail man, eighty-three years old. He was brought in by his wife Sally, a well-dressed woman of seventy-two years, and his daughter Lillian. He is rather unsteady on his feet, but rejected assistance into his chair. He appeared hard of hearing and the interviewer had to repeat some questions a number of times.

2. Description of presenting problem:

Sally reports that Sherman has been hearing noises in the apartment for the past four weeks and has been experiencing restless nights, being unable to sleep. He complained so much that Sally had a contractor come to the house and check out the situation with the hope that it would calm her husband and allay his fears. According to Sally, these complaints seem to "start out of the blue," with his behavior becoming more and more strange and fearful.

When Sherman was asked how he was feeling, his wife answered for him. Subsequently the interviewer spoke with Sherman alone, reassuring Sally that she would have an opportunity to speak afterwards. After she had left the room, Sherman began to cry. He appears quite depressed over the fact that his wife is rejecting him sexually. Nine years ago he had his prostate removed. Since that time, he has been unable to have an erection. He states that his wife turns away whenever he approaches her, even for affection. He says she thinks that the idea of having sex with him now is ridiculous.

When she was seen alone, Sally stated that she felt her husband had no reason to be miserable. She feels that his current craziness is doing a lot to increase her anxiety. When asked about her relationship with her husband, she said "You mean sex?...There is nothing to be upset about; everything's fine."

When asked about the noises he was hearing, Sherman explained that the neighbors upstairs have a noisy washing machine. Later, his wife stated that she too hears the washing machine. Sherman seemed anxious to tell me stories about his children and grandchildren. He said he doesn't have much to do now that he's retired. Until he sold the business in 1970, he owned and operated his own small auto parts store.

3. Current situational determinants:

a. Hearing noises
b. Restlessness at night

4. Description of social network:

Sally says that she and her husband do not go out, unless it is to visit the family. Neither of them drives and she says it is too much trouble to take the bus because the bus stop is not close and her husband has to rest every couple of hundred feet. They have two married daughters: Lillian, who lives in Van Nuys, and her older sister Marsha, who lives in Hacienda Heights. Sally and Sherman see their daughters on alternate weekends, and the two girls trade off driving in to pick up their parents. Sally describes their relationship with their daughters as "close, as close as it could be," except that recently Marsha has been seeing a psychiatrist who "twisted her mind to suit him" and turned her against her mother. When Lillian was seen alone, she described her mother as domineering and expressed concern that her mother's "overbearing nature" contributes in some ways to her father's problems. Lillian further reported that during the last year her mother has taken over everything Sherman used to do in the house--banking, shopping, bill paying, household repairs.

(Gatz, Pearson & Zemansky, 1982)

Though Sherman and Sally both used to love to play cards, in the past few months they have been unable to get rides to the senior center.

5. Mental status screening:

Sherman scored 8 out of 10 correct on the Kahn Mental Status Questionnaire (MSQ). He missed the year and the president's name (stating Carter instead of Reagan). The Face-Hand test was negative. Sally began to take the Beck Depression Inventory but stopped in the middle and refused to finish.

6. (a) Sleep and appetite: Sally reports no sleep problems or appetite loss. Sherman's appetite is sound but the two concur in describing his sleep as restless.

(b) Brief medical history: Heart disease, hypertension, osteoarthritis, and dizziness have plagued Sherman for several years. His prostate operation was in 1974; he was diagnosed as having a heart condition four years ago.

(c) Current medications: Sherman is on several different medications, which Sally says she gives him when she feels he needs them:
Hygroton 100 mg every other day
Meclizine 12.5 mg daily
Motrin 400 mg 4 times/day
Nitroglycerin as needed
Donnatal every 4 hrs as needed
Mylanta every 4 hrs as needed
Dalmane 30 mg at bedtime

(d) Suicidal ideation: Sherman says his life is no good anymore and he wishes he were dead. He has no plan for suicide, however.

(e) Sensory loss: Hearing loss in both of Sherman's ears.

7. History of prior behavior problems/psychiatric treatment:

Sally said that neither of them had ever sought help previously. However, when seen alone, Sherman said that he and Sally had marriage counseling approximately three years ago, dealing with issues of his health and Sally's lack of consideration toward it.

CODE # _____

SET 1

INSTRUCTIONS:

Attached are two intake summaries adapted from real case material. Assume each is dated January 1983. Read each summary; then, based on the information given, answer the following five questions about each case. Use as much paper as you need, and write your code number on each piece. Start a new page for the second case, and put the client's name at the top of each write up. If some of what is being asked for is unfamiliar to you, just respond however you can. Although it might be possible for some of you to linger over this task for quite some time, we are asking you to allow about 20 minutes per case and definitely not to take over an hour altogether.

1. How would you formulate the problem (for example, what is your diagnostic impression? What has brought the individual into treatment now?)

2. Write up Goals for Treatment (that is, list the issues to be addressed in treatment and the type of change that you would hope to achieve)

3. Write up a Treatment Plan (that is, make recommendations, list the steps that you would take as the therapist, and describe your treatment approach)

4. What more would you want to know (what assessment questions are left unanswered?)

5. How do you view the prognosis.

Remember, please do not discuss these cases with your classmates.

(Gatz, Pearson & Zemansky, 1982)

Client: Reggie W.

1. Behavior during interview and physical description:

Reggie is a 74-year-old retired actor. He was brought in for an assessment by his 69-year-old sister, Fran, who is concerned about Reggie's memory as well as her own difficulty in coping with him. He appeared for the interview neatly dressed in a suit and tie. He is very trim and slight in build. His disposition seemed pleasant and cooperative, even though he appeared to be unsure of himself. He looked to his sister for reassurance, particularly during testing. Providing reinforcement helped his confidence a bit, although it did not seem to alter his performance. He showed a right-handed tremor that increased during testing. Fran said that the doctor attributes this to nervousness. Several times during the session Reggie questioned where he was, seeming to be convinced that he had been to the clinic before. While Fran provided the developmental history, Reggie was asked to wait in the lobby; during that time he wandered throughout the clinic in an effort to find his sister.

2. Description of presenting problem:

Fran reports that Reggie has been experiencing noticeable memory problems since 9 years ago, when he underwent hip surgery. Fran believes that memory changes may have been occurring prior to that time, but were unnoticed. The surgery definitely exacerbated them, from her viewpoint. For a period of time following the surgery, Reggie became belligerent with his hospital roommates and nurses for not "speaking their lines properly." Since that time, Fran describes a pattern of slow and gradual decline in functioning. Currently, Reggie expresses a fear of being alone, yet is becoming increasingly introverted. He has some awareness of his memory problems, stating that "things slip away just after I say them." Reggie watches T.V. and leafs through magazines during the day, but usually cannot recall what he has just read. He can keep his apartment in order, but experiences lapses where he will forget to take out the garbage for a week or, conversely, will repeatedly polish his shoes when it is unnecessary.

In June of 1980 Reggie got lost while driving and the policeman whom he asked for directions turned his name into DMV for re-examination. He was unable to pass the drivers' test and hasn't driven since.

Two months ago, Reggie flew to New York to visit his nephew. The first day there he called Fran and invited her over for dinner. When Fran reminded him that she was on the west coast, Reggie became distraught. He could not understand where he was, how he had gotten there, or why he was there, in spite of his nephew's explanation. Fran said that he appeared to worsen after he returned home.

3. Current situational determinants:

Fran's concern is about Reggie's future. She sees Reggie's difficulties as a process of old age. She and her brother have never been close (especially at the height of Reggie's career) and, although she has been helping out, she does not want to be responsible for Reggie's daily living. She would like to hire a live-in for her brother or work out something to keep him in his own home. She is seeking a confirmation from us that this is the best path to follow. She would like a diagnosis of her brother's condition, since she feels the time may come when he has to be placed in a nursing home and she wants to be prepared should this occur.

(Gatz, Pearson & Zemansky, 1982)

4. Description of social network:

Reggie walks to a nearby coffee shop several times a week for lunch. According to a neighbor with whom Fran has spoken, he does not socialize when he's there. If other residents in his apartment building invite him to participate in social activities, he will occasionally join in, though he will frequently make up excuses as to why he can't.

5. Mental status screening:

Five errors on the Kahn Mental Status Questionnaire (MSQ). Two omissions on the Face-Hand test (hands omitted on first and third trials).

6. a. Sleep and appetite:

Sleeps well. Although he has a hearty appetite, he has never cooked for himself. At most, he heats T.V. dinners and canned soup. He does his own shopping.

b. Brief medical history:

Hip surgery nine years ago to place a steel pin in his deteriorated hip socket. In a routine physical three years ago, his doctor diagnosed him as having "arteriosclerosis, neurosis, and anxiety." The doctor prescribed Haldol, which he takes "as needed".

c. Current medications:

Haldol (dosage unknown)
Vitamin C--1000 mg
Multiple vitamins
Hydergine
Diamox (for glaucoma)
Timoptic drops

7. History of prior behavioral problems/psychiatric treatment:

Fran does not know how Reggie dealt with previous problems he encountered, though to her knowledge no psychological treatment was sought.

(Gatz, Pearson & Zemansky, 1982)

Client: Ruth T.

1. Behavior during interview and physical description:

Ruth is a 69 year old woman who was brought in to the clinic by her neighbors Jim and Jay because of some problems she has been having with her memory. Ruth's body language and appearance were those of a depressed person. She sat slumped in her chair, fidgeting constantly with her eye glasses. During the interview she became very anxious and agitated when she experienced memory difficulties. Her facial expression was sad, and there was little change in her expression when she discussed pleasant activities. She was teary during much of the interview.

2. Description of presenting problem:

Ruth first experienced memory problems following the sudden death of her only daughter in an automobile accident, which she said occurred 1½ years ago. During the interview, she had a hard time presenting historical information and demonstrated time distortion (i.e., Jim said that the daughter had been killed only six months ago). She described some of the problems that she's been experiencing: suddenly forgetting where she is if she goes out shopping or banking and misplacing money and other items. Ruth herself had a car accident recently, where her fender was damaged when she pulled into an intersection without looking; she explains that her mind had wandered. Since then, because of having difficulty concentrating on driving, she has given it up and plans to sell her car. However, she refuses to take the bus, so that her activities have become restricted. Ruth described herself as not being able to gather up the energy to do social things. Jim and Jay, who have been friends of Ruth for eight years, describe her as always having been independent, one who keeps to herself. Ruth spends her days reading and watching T.V. She used to enjoy knitting but has given it up because there is no one to whom to give the things she has made.

3. Current situational determinants:

Memory problems subsequent to daughter's death.

4. Description of social network:

Ruth's marriage to a field geologist at Atlantic Richfield ended in divorce after 12 years. She describes herself as raising her daughter pretty much alone. She worked as a speech therapist for the L.A. school system for over 30 years. Ruth's son-in-law and three granddaughters live in Riverside. She said that she is in close contact with her family and sees them quite often; however, Jim says that Ruth hasn't seen her family for quite awhile and was not visited by them over the Christmas holidays. Ruth has no other family, having recently lost two cousins with whom she corresponded for years by mail. Her only friends of any consequence are Jim and Jay. They, however, are substantially younger and lead their own social lives. Ruth talks to them every day by phone, when they remind her of things to do such as meal preparation. They also help fix things in her home. A great source of pleasure for Ruth currently is a pet dog which she acquired from Pet Orphans four months ago.

(Gatz, Pearson & Zemansky, 1982)
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5. Mental Status Screening:

On the Kahn Mental Status Questionnaire (MSQ), Ruth got 7 out of the 10 items correct. She missed the year, the address and her age. On the Face-Hand test she made no errors. On the Beck Depression Inventory her score was 5. While she had expressed feelings of sadness and discouragement earlier in the interview, her frequent response to Beck items was "I take one day at a time. Life isn't bad". In response to the item about whether she cried more now than in the past, she responded, "I never cry". When reminded of a crying spell she had earlier in the interview, she answered that those tears were not because she was sad (despite the fact that she had been talking about her daughter's death at the time).

6. a. Sleep and appetite:

Ruth says that her sleep is usually good; Jim and Jay kidded her about her catnapping. She has lost over 10 pounds in the last five months.

b. Brief medical history:

Ruth has not seen a physician in the last four years. She describes herself as healthy. She has arthritis in her hands and complained of occasional tension headaches for which she takes Tylenol. In addition, Jim told me when I talked to him separately (after seeing Ruth alone) that she has complained to him of trouble with her bowels and that she often has diarrhea.

c. Current medications:

None reported.

d. Suicidal ideation:

Ruth stated, "I don't believe in that sort of thing".

e. Sensory loss:

None.

7. History of prior behavioral problems/psychiatric treatment:

Ruth admitted she is very wary of psychology and the people who work in it, and expressed uncertainty at the end of the interview about whether she wanted to come back in for counseling. Jim and Jay are very willing to provide transportation to the clinic if she decides to come.